


Contract Year Ending 2024
Capitation Rate Certification
Arizona Long Term Care System – Elderly and Physical Disability Program

October 1, 2023 through September 30, 2024

Prepared for:
The Centers for Medicare & Medicaid Services

Prepared by:
AHCCCS Division of Business and Finance

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Introduction and Limitations

The purpose of this rate certification is to provide documentation for compliance with the applicable provisions of 42 CFR Part 438. This includes the data, assumptions, and methodologies used in the development of the actuarially sound capitation rates for Contract Year Ending 2024 (CYE 24) for the Arizona Long Term Care System (ALTCS) Elderly and Physical Disability (ALTCS-EPD) Program. Programs under AHCCCS and their respective contracts have been aligned with the federal fiscal year since October 1, 2018. All contract years referenced below cover the timeframe from October 1 of one year through September 30 of the following year (e.g., CYE 24 covers the timeframe between October 1, 2023, through September 30, 2024).

This rate certification was prepared for the Centers for Medicare & Medicaid Services (CMS), or its actuaries, for review and approval of the actuarially sound certified capitation rates contained herein. This rate certification may not be appropriate for any other purpose. The actuarially sound capitation rates represent projections of future events. Actual results may vary from the projections.

This rate certification may also be made available publicly on the Arizona Health Care Cost Containment System (AHCCCS) website or distributed to other parties. If this rate certification is made available to third parties, then this rate certification should be provided in its entirety. Any third party reviewing this rate certification should be familiar with the AHCCCS Medicaid managed care program, the provisions of 42 CFR Part 438 applicable to this rate certification, the 2023-2024 Medicaid Managed Care Rate Development Guide (2024 Guide), Actuarial Standards of Practice, and generally accepted actuarial principles and practices.

The 2024 Guide describes the rate development standards and appropriate documentation to be included within Medicaid managed care rate certifications. This rate certification has been organized to follow the 2024 Guide to help facilitate the review of this rate certification by CMS.

Section I Medicaid Managed Care Rates

The capitation rates included with this rate certification are considered actuarially sound according to the following criteria from 42 CFR § 438.4(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations. CMS may require a State to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or the covered populations.
- § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
- § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
- § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.

- § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

The actuary has followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), CMS, and federal regulations. In particular, the actuary referenced the below during the development of the actuarially sound capitation rates:

- Actuarial Standards of Practice (ASOPs) applicable to Medicaid managed care rate setting which were effective before the start date of the rating period:
  - ASOP No. 1 - Introductory Actuarial Standard of Practice,
  - ASOP No. 5 - Incurred Health and Disability Claims,
  - ASOP No. 12 - Risk Classification (for All Practice Areas),
  - ASOP No. 23 - Data Quality,
  - ASOP No. 25 - Credibility Procedures,
  - ASOP No. 41 - Actuarial Communications,
  - ASOP No. 45 - The Use of Health Status Based Risk Adjustment Methodologies,
  - ASOP No. 49 - Medicaid Managed Care Capitation Rate Development and Certification, and
  - ASOP No. 56 - Modeling.
- The 2016 and 2020 Medicaid and CHIP Managed Care Final Rules (CMS-2390-F and CMS-2408-F)
- FAQs related to payments to MCOs and PIHPs for IMD stays
- The 2023-2024 Medicaid Managed Care Rate Development Guide (2024 Guide) published by CMS

Throughout this actuarial certification, the term “actuarially sound” will be defined as in ASOP 49 (consistent with the definition at 42 CFR § 438.4(a)):

> “Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.”

As stated on pages 2 and 3 of the 2024 Guide, CMS will also use these three principles in applying the regulation standards:

- the capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
- the rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
- the documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR Part 438 and generally accepted actuarial principles and practices.

I.1. General Information

This section provides documentation for the General Information section of the 2024 Guide.

I.1.A. Rate Development Standards

I.1.A.i. Standards and Documentation for Rate Ranges

The section of the 2024 Guide notes that standards and documentation expectations are not different for capitation rates and capitation rate ranges, except where otherwise stated.

I.1.A.ii. Rating Period

The CYE 24 capitation rates for the ALTCS-EPD Program are effective for the 12-month time period from October 1, 2023, through September 30, 2024.

I.1.A.iii. Required Elements

I.1.A.iii.(a) Letter from Certifying Actuary

The actuarial certification letter for the CYE 24 capitation rates for the ALTCS-EPD Program, signed by Matthew C. Varitek, FSA, MAAA, is in Appendix 1. Mr. Varitek meets the requirements for the definition of an Actuary described at 42 CFR § 438.2 which is provided below for reference.

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

Mr. Varitek certifies that the CYE 24 capitation rates for the ALTCS-EPD Program contained in this rate certification are actuarially sound and meet the standards within the applicable provisions of 42 CFR Part 438.

I.1.A.iii.(b) Final and Certified Capitation Rates

The final and certified capitation rates by rate cell are in Appendix 2. Additionally, the ALTCS-EPD Program contract includes the final and certified capitation rates by rate cell in accordance with 42 CFR § 438.3(c)(1)(i). The ALTCS-EPD Program contract uses the term risk group instead of rate cell. This rate certification will use the term rate cell when identifying a population at the certified capitation rate level (as shown in Appendix 2, Appendix 7, and Appendix 8b) to be consistent with the applicable provisions of 42 CFR Part 438 and the 2024 Guide and will use the term risk group when identifying a population not at the certified capitation rate level, e.g., the Duals risk group represents members who are dually eligible for Medicare and Medicaid in the ALTCS-EPD Program.

I.1.A.iii.(c) Program Information

This section of the rate certification provides a summary of information about the ALTCS-EPD Program.

I.1.A.iii.(c)(i) Summary of Program

I.1.A.iii.(c)(i)(A) Type and Number of Managed Care Plans

The ALTCS-EPD Program contracts with three managed care organizations. The number of managed care organizations contracted with the Program varies by Geographical Service Area (GSA). Each ALTCS-EPD Program Contractor must have a dual eligible special needs plan (D-SNP) certified by either AHCCCS or Arizona Department of Insurance (ADOI). Table 1a below provides the counties and zip codes covered in each GSA. Table 1b provides information about the GSAs each Contractor is responsible for, as well as the associated D-SNP for each Contractor.

Table 1a: GSA and Counties

GSA	Counties
North	Apache, Coconino, Mohave, Navajo, and Yavapai
Central	Gila, Maricopa, and Pinal (excluding zip codes 85542, 85192, and 85550)
South	Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma (including zip codes 85542, 85192, and 85550)

Table 1b: GSA and D-SNP Information by Contractor

Contractor	GSAs	D-SNP
Banner – University Family Care (Banner – UFC)	Central, South	Banner – University Care Advantage
Mercy Care	Central, South (Pima County Only)	Mercy Care
UnitedHealthcare Community Plan (UnitedHealthcare)	North, Central	Arizona Physicians IPA

I.1.A.iii.(c)(i)(B) General Description of Benefits

This certification covers the ALTCS-EPD Program. This program delivers long-term, acute, behavioral health, and case management services to eligible members who are elderly and/or have physical disabilities.

Additional information regarding covered services can be found in the Scope of Services section of the ALTCS-EPD contract.

For the CYE 24 rating period, the projected expenses associated with the administration of COVID-19 vaccines are not included in the capitation rates; all COVID-19 vaccine costs in the base data period were removed as part of rate developments, described below in Section I.2.B.iii.(d). AHCCCS Contractors are responsible for these expenses and will be reimbursed for these expenses on a non-risk basis via periodic cost-settlement payments based upon adjudicated/approved encounter data subject to the two-year claiming rule, as noted in contract and below in Section I.1.B.x.(c).

I.1.A.iii.(c)(i)(C) Area of State Covered and Length of time Program in Operation

The ALTCS-EPD Program operates on a statewide basis and, since the late 1980s, it has been the health plan for individuals who are elderly and/or have a physical disability.

I.1.A.iii.(c)(ii) Rating Period Covered

The rate certification for the CYE 24 capitation rates for the ALTCS-EPD Program is effective for the 12-month time period from October 1, 2023, through September 30, 2024.

I.1.A.iii.(c)(iii) Covered Populations

The populations covered under ALTCS-EPD Program are individuals who are elderly and/or have physical disabilities and have been deemed eligible to receive long-term care services through ALTCS.

Additional information regarding covered populations can be found in the Enrollment and Disenrollment section of the ALTCS-EPD contract.

The ALTCS-EPD Program has two risk groups: rate cells for members who are dually eligible for Medicare and Medicaid ("Duals") and rates cell for members who are not eligible for Medicare ("Non-Duals"). The capitation rates fund prospective and prior period coverage (PPC) of members for long-term, acute, behavioral health and case management services. The rates also include coverage of acute care only services for members that qualify for ALTCS but decline to receive long-term care services. Rates for the ALTCS-EPD population differ by GSA and Contractor.

I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria

ALTCS determines eligibility for ALTCS-EPD services through eligibility offices located throughout the State. Further information is available in the Eligibility section of the ALTCS-EPD Contract.

Under the maintenance of effort (MOE) requirements included in the Families First Coronavirus Response Act (FFCRA), with a few exceptions as noted in the law, members who were eligible at the beginning of the COVID-19 public health emergency (PHE), or who became eligible during the PHE, remained treated as eligible for such benefits through March 31, 2023, or later, based on the Arizona renewal plan submitted to CMS. Under the Consolidated Appropriations Act, 2023 (CAA) which ended the Medicaid continuous coverage protection as of March 31, 2023, states were allowed to resume disenrollment of people who are no longer eligible for Medicaid eligibility after a complete redetermination of each person's eligibility for all categories of Medicaid, with the timeline expected for all renewals to be completed within 14 months of the start of the state's renewal plan.

In practice, enrollment in the ALTCS-EPD Program is predicated upon meeting the eligibility requirements for ALTCS, as defined in the contract and state statute, and being elderly and/or physically disabled; physically disabilities do not generally resolve, and health needs generally increase as members age, so it is unlikely a member would lose ALTCS eligibility on the basis of no longer needing the level of medical support required by the ALTCS eligibility statutes, but in that unlikely event, the member would transition to the ALTCS Transitional Program, for members who fail to be at "immediate risk of institutionalization", which provides the same level of care as ALTCS with the exception of limiting institutional services to 90 days per admission. There are three allowable income limit definitions for ALTCS financial eligibility under the Arizona 1115 Waiver. The first definition is income equal to or less than 300 percent of the Federal Benefit Rate (approximately 222 percent of the Federal Poverty Limit (FPL)), as used by the Social Security Administration (SSA) to determine eligibility for Supplemental Security Income (SSI); the second and third definitions cover the "Freedom to Work" groups (state

optional TXIX coverage groups under the ALTCS program in the 1115 Waiver), which cover a) individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL and b) employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL. These higher allowable income limits for ALTCS also make it unlikely a member would lose financial eligibility once determined eligible for ALTCS-EPD based on their age and/or physical disability. As such, the unwinding of the PHE is not expected to have a material impact on the ALTCS-EPD Program enrollment.

There are no expected changes to the eligibility and enrollment criteria. Therefore, there are no expected impacts on the population to be covered under the EPD program during CYE 24.

I.1.A.iii.(c)(v) Summary of Special Contract Provisions Related to Payment

This rate certification includes special contract provisions related to payment as defined in 42 CFR § 438.6. The special contract provisions related to payment included in the CYE 24 capitation rates are:

- Risk Corridor Arrangement (42 CFR § 438.6(b)(1))
- Reinsurance Arrangement (42 CFR § 438.6(b)(1))
- Alternative Payment Model (APM) Initiative – Performance Based Payments (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Incentive Arrangement) (42 CFR § 438.6(b)(2))
- APM Initiative – Quality Measure Performance (Withhold Arrangement) (42 CFR § 438.6(b)(3))
- Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) (42 CFR § 438.6(c)(1)(iii)(A))
- Differential Adjusted Payments (DAP) (42 CFR § 438.6(c)(1)(iii)(C))
- Access to Professional Services Initiative (APSI) (42 CFR § 438.6(c)(1)(iii)(C))
- Pediatric Services Initiative (PSI) (42 CFR § 438.6(c)(1)(iii)(C))
- Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) (42 CFR § 438.6(c)(1)(iii)(C))
- Nursing Facility Supplemental Payments (NF-SP) (42 CFR § 438.6(c)(1)(iii)(B))

Documentation on these special contract provisions related to payment can be found in Section I.4 of this rate certification.

I.1.A.iii.(c)(vi) Retroactive Capitation Rate Adjustments – Not Applicable

Not applicable. This rate certification does not cover retroactive adjustments for previous capitation rates.

I.1.A.iv. Rate Development Standards and Federal Financial Participation (FFP)

All proposed differences among the CYE 24 capitation rates for the ALTCS-EPD Program are based on valid rate development standards and are not based on the rate of FFP for the populations covered under the ALTCS-EPD Program.

I.1.A.v. Rate Cell Cross-subsidization

The CYE 24 capitation rates were developed at the rate cell level. Payments from rate cells do not cross-subsidize payments of other rate cells.

I.1.A.vi. Effective Dates of Changes

The effective dates of changes to the ALTCS-EPD Program are consistent with the assumptions used to develop the CYE 24 capitation rates for the ALTCS-EPD Program.

I.1.A.vii. Minimum Medical Loss Ratio

The certified capitation rates were developed so each ALTCS-EPD Program Contractor would reasonably achieve a medical loss ratio, as calculated under 42 CFR § 438.8, of at least 85 percent for CYE 24.

I.1.A.viii. Conditions for Certifying Capitation Rate Range – Not Applicable

Not applicable. The actuary is not certifying capitation rate ranges.

I.1.A.ix. Certifying Actuarially Sound Capitation Rate Range – Not Applicable

Not applicable. The actuary is not certifying capitation rate ranges.

I.1.A.x. Generally Accepted Actuarial Principles and Practices

I.1.A.x.(a) Reasonable, Appropriate, and Attainable Costs

In the actuary's judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To the actuary's knowledge, all reasonable, appropriate, and attainable costs have been included in the rate certification.

I.1.A.x.(b) Rate Setting Process

Adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR § 438.4. There are no adjustments to the rates performed outside the rate setting process.

I.1.A.x.(c) Contracted Rates

Consistent with 42 CFR § 438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell. The CYE 24 capitation rates certified in this report represent the contracted rates by rate cell.

I.1.A.xi. Rates from Previous Rating Periods – Not Applicable

Not applicable. Capitation rates from previous rating periods are not used in the development of the CYE 24 capitation rates for the ALTCS-EPD Program.

I.1.A.xii. Evaluation of COVID-19 PHE and Unwinding

This section of the 2024 Guide includes CMS recommendations for risk mitigation strategies for rating periods impacted by the PHE and continuing after the end of the PHE until enrollment is expected to stabilize. All risk mitigation strategies are addressed in the contract and below in Section I.4.C. and will

be submitted to CMS prior to the start of the rating period in accordance with the specific documentation requirements under 42 CFR § 438.6(b)(1).

This section also requests description of evaluations conducted, and the rationale for any applicable assumptions included or not included in rate development related to the COVID-19 PHE and related unwinding within the rate certification. Information on all assumptions included in the rate development, based on the available and applicable state specific, as well as nationally and regionally applicable, data (outlined below in Section I.1.B.x.(a)), to address the direct and indirect impacts of the COVID-19 PHE and related unwinding are described in each of the sections below:

- I.1.A.iii.(c)(i)(B) General Description of Benefits
- I.1.A.iii.(c)(iv) Eligibility or Enrollment Criteria
- I.1.B.viii.(a) Comparison to Previous Rate Certification
- I.1.B.x.(a) Available Applicable Data
- I.1.B.x.(b) Accounting for Direct and Indirect Impacts
- I.1.B.x.(c) COVID-19 Costs Paid Outside of Capitation Rates (Non-Risk)
- I.1.B.x.(d) Risk Mitigation Strategies
- I.2.B.iii.(d) Changes in the Program
- I.2.B.iii.(e) Exclusions of Payments or Services
- I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies
- I.3.B.iii.(a)(i) Projected Benefit Cost Trends Data

Additional evaluation conducted related to the COVID-19 PHE and related unwinding which did not result in adjustments to the rate development for CYE 24 varies by program. The actuary reviewed monthly utilization patterns during the CYE 22 base year and did not observe any induced underutilization attributable to COVID-19 waves that would necessitate an adjustment to normalize the base data. The LTSS and acute care services received by the members in the ALTCS-EPD Program were not affected by the PHE in the same manner as acute care services for traditional populations. Similarly, the ALTCS-EPD Program enrollment was not impacted by the MOE requirements of the PHE in the same way that other AHCCCS programs were, as described above in Section I.1.A.iii.(c)(iv), which resulted in the evaluation of changes in acuity being negligible as stated below in I.1.B.x.(b), and so while the population was evaluated for acuity changes, no adjustments to the rate were made as they were unnecessary. Changes in Arizona COVID-19 case rates were reviewed both in general and with respect to the different COVID-19 variants in the base data time period and more recently, but no adjustments for expected new variants were included in capitation rate development.

I.1.A.xiii. Rate Certification Procedures

I.1.A.xiii.(a) Timely Filing for Claiming Federal Financial Participation

This section of the 2024 Guide reminds states of the responsibility to comply with the time limit for filing claims for FFP specified in section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95. Timely filing of rate certifications to CMS will help mitigate timely filing concerns.

I.1.A.xiii.(b) CMS Rate Certification Requirement for Rate Change

This rate certification documents that the ALTCS-EPD Program capitation rates will be changing effective October 1, 2023.

I.1.A.xiii.(c) CMS Rate Certification Requirement for No Rate Change – Not Applicable

Not applicable. This rate certification will prospectively change the ALTCS-EPD Program capitation rates effective October 1, 2023.

I.1.A.xiii.(d) CMS Rate Certification Circumstances

This section of the 2024 Guide provides information on when CMS would not require a new rate certification, which include increasing or decreasing capitation rates up to 1.5% per rate cell for certified rates per rate cell, in accordance with 42 CFR §§ 438.7(c)(3) and 438.4(b)(4), increasing or decreasing capitation rates up to 1% within a certified rate range, in accordance with 42 CFR § 438.4(c)(2), and applying risk scores to capitation rates paid to plans under a risk adjustment methodology described in the rate certification for that rating period and contract, in accordance with 42 CFR § 438.7(b)(5)(iii).

I.1.A.xiii.(e) CMS Contract Amendment Requirement

CMS requires a contract amendment be submitted whenever capitation rates change for any reason other than application of an approved payment term (e.g., risk adjustment methodology) which was included in the initial managed care contract. The state will submit a contract amendment to CMS as required.

I.1.A.xiii.(f) CMS Contract and Rate Amendment Requirement for Changes in law

CMS requires a contract amendment and capitation rate amendment in the event that any State Medicaid program feature is invalidated by a court of law, or a change in federal statute, regulation, or approval. The rate amendment adjusting the capitation rates must remove costs specific to any program or activity no longer authorized by law, taking into account the effective date of the loss of program authority.

I.1.B. Appropriate Documentation

I.1.B.i. Capitation Rates or Rate Ranges

The actuary is certifying capitation rates for each rate cell.

I.1.B.ii. Elements

This rate certification documents all the elements (data, assumptions, and methodologies) used to develop the CYE 24 capitation rates for the ALTCS-EPD Program.

I.1.B.iii. Capitation Rate Cell Assumptions

This section of the 2024 Guide notes that the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for the variation.

All such assumptions and adjustments are described in the rate certification.

I.1.B.iv. Capitation Rate Range Assumptions – Not Applicable

Not applicable. The actuary did not develop capitation rate ranges.

I.1.B.v. Rate Certification Index

The table of contents that follows the cover page within this rate certification serves as the index. The table of contents includes the relevant section numbers from the 2024 Guide. Sections of the 2024 Guide that do not apply will be marked as "Not Applicable"; any section wherein all subsections are not applicable will be collapsed to the section heading.

I.1.B.vi. Assurance Rate Assumptions Do Not Differ by Federal Financial Participation

All proposed differences in the assumptions, methodologies, or factors used to develop the certified CYE 24 capitation rates for the covered populations under the ALTCS-EPD Program are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs, in compliance with 42 CFR § 438.4(b)(1). CMS may request additional documentation and justification that any differences in the assumptions, methodologies, or factors used in the development of the capitation rates represent actual cost assumptions based on the characteristics and mix of the covered services or the covered populations.

I.1.B.vii. Differences in Federal Medical Assistance Percentage

All covered populations under the ALTCS-EPD Program receive the regular FMAP.

I.1.B.viii. Comparison to Prior Rates

I.1.B.viii.(a) Comparison to Previous Rate Certification

Comparisons between the most recent certified CYE 23 ALTCS-EPD Program capitation rates and the CYE 24 capitation rates being certified in this actuarial rate certification are available in Appendix 3.

The 2024 Guide requires descriptions of what is leading to large, or negative changes in rates from the previous rating period. As in past years, the AHCCCS DBF Actuarial Team has defined any change greater than 10% as a large change, and any capitation rate that was less than the rate for the same rate cell in the prior year was a negative change in the rate. The 2024 Guide requests a comparison to the final certified rates in the previous rate certification. Those comparisons are available in Appendix 3. There are no large changes in the CYE 24 capitation rates as compared to the most recent certified CYE 23 capitation rates. There are two non-dual rate cells which have decreased capitation rates over the prior year, one in the North GSA and one in the Central GSA. In both of these rate cells, the decreases are influenced by lower aggregate PMPM expense trends assumed in the CYE 24 capitation rates for these rate cells than assumed in the CYE 23 rates.

I.1.B.viii.(b) Material Changes to Capitation Rate Development

There have been no material changes since the last rate certification other than those described elsewhere in the certification.

I.1.B.viii.(c) *De Minimis* Changes to Previous Period Capitation Rates

The state did not adjust the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 CFR § 438.7(c)(3).

I.1.B.ix. Future Rate Amendments

There are no known, or expected, future amendments to the ALTCS-EPD Program capitation rates.

I.1.B.x. Addressing COVID-19 PHE and Unwinding Impacts

I.1.B.x.(a) Available Applicable Data

The AHCCCS DBF Actuarial Team and AHCCCS DBF financial analysts have reviewed data, regulations, and information from a variety of applicable sources to address the COVID-19 PHE and related unwinding in rate setting. For CYE 24 rate development, AHCCCS DBF Actuarial Team has incorporated information regarding the end date of the Medicaid continuous coverage protection, including Arizona's plan for renewals as submitted to CMS, and disenrollment information available through June. The progress of redeterminations and subsequent disenrollments for ineligibility will continue to be monitored by the AHCCCS DBF Actuarial Team. Further details about state specific and national data sources are listed below.

- State Data Sources
    - AHCCCS historical and current encounter data including utilization and costs by category of service, risk group, GSA, and program
    - AHCCCS telehealth utilization and cost data by risk group, GSA, and program
    - AHCCCS non-emergency transportation (NEMT) utilization and cost data by risk group, GSA, and program
    - AHCCCS historical and current enrollment by risk group, GSA, and program
    - Historical and ongoing COVID-19 case rates for Arizona (not restricted to Medicaid populations)
    - AHCCCS COVID-19 testing by risk group, GSA, and program
    - AHCCCS COVID-19 vaccination rates by risk group, GSA, and program
    - AHCCCS child and adolescent well-care visit rates
    - Historical and current HCBS/NF placement rates; analysis of the monthly progression of placement rates informed the actuary's decision to forecast HCBS/NF placement rates for CYE 24 using the most recent available data
    - Arizona Medicaid eligibility information, provided by the AHCCCS Division of Member and Provider Services (DMPS), which identified members who, if not for the MOE, would have been determined ineligible and disenrolled; this information was used in evaluating potential changes in acuity of the population covered under the ALTCS-EPD Program population after March 31, 2023, when states could disenroll people no longer eligible for Medicaid
- National Data Sources
    - Daily case rate, death rate, and vaccination rate data for Arizona collated and cleaned by the Centers for Disease Control

- Consumer and Producer price inflation data published by the Bureau of Labor Statistics
- National webinars discussing various impacts of the response to the COVID-19 PHE and the end of continuous coverage protections
- Policy memoranda and newsletters related to available PHE unwinding flexibilities and considerations published by various universities and government agencies (examples below):
  - State Health Official Letter 23-002
  - Princeton University State Health and Value Strategies (SHVS):
    - Planning for the end of the Continuous Coverage Requirement
    - Best Practices for Publicly Reporting State Unwinding Data
    - State Reporting to Monitor the Unwinding of the Medicaid Continuous Coverage Requirement
  - CMS Policy Guidance FAQ dated May 12, 2023, on unwinding the continuous enrollment requirement
  - State Medicaid Director Letter 23-004

I.1.B.x.(b) Accounting for Direct and Indirect Impacts and Related Unwinding

The list above in I.1.A.xii. details the sections of the certification which describe assumptions included in the rate development to address the direct and indirect impacts of the COVID-19 PHE and related unwinding. A brief narrative summary of how the capitation rates account for the direct and indirect impacts of the COVID-19 PHE and related unwinding through the incorporation of the assumptions in the rate development, described in those sections of the certification, is provided below.

The CYE 24 capitation rates account for the direct and indirect impacts of the COVID-19 PHE and related unwinding by removing COVID-19 vaccine costs from the base data since AHCCCS has a non-risk based cost settlement with the Contractors for COVID-19 vaccines, by removing COVID-19 test costs from the base data period and modeling projected COVID-19 testing costs for the rating period, by using a base data experience period that reflects changes in service delivery expected to continue beyond the pandemic, such as increased telehealth usage, and by forecasting HCBS/NF placement using the most recent available data to reflect the return to a new equilibrium.

As noted above in Section I.1.A.iii.(c)(iv), the MOE requirements under the FFCRA are unlikely to have impacted the membership under the ALTCS-EPD Program as eligibility is predicated upon needing the level of medical support required by the ALTCS eligibility statutes, and the allowable income limits are significantly higher than other AHCCCS programs. Any member leaving the ALTCS-EPD Program due to no longer meeting the ALTCS medical support requirements will have their Medicaid eligibility continued under the ALTCS Transitional Program, and members are unlikely to exceed the allowable income limits. Because of these unique aspects of eligibility for the ALTCS-EPD Program there are not measurable changes expected in the acuity of the membership due to the ending of the continuous coverage protections effective March 31, 2023, so no acuity adjustment was necessary.

I.1.B.x.(c) COVID-19 Costs Paid Outside of Capitation Rates (Non-Risk)

Costs for COVID-19 vaccines and administration of COVID-19 vaccines are covered on a non-risk basis outside of the capitation rates. Covering these COVID-19 costs on a non-risk basis outside of the capitation rates required removing related costs from the base data period, as described in Section I.2.B.iii.(d).

I.1.B.x.(d) Risk Mitigation Strategies

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits and to protect Contractors from excessive losses. This risk-sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 24 contract will continue AHCCCS' long-standing program policy and will include risk corridors. For the CYE 24 rating period, AHCCCS is continuing the cost-settlement for administration of COVID-19 vaccines and carving these costs out of the capitation rates. This is the only risk mitigation strategy utilized specifically for COVID-19.

I.2. Data

This section provides documentation for the Data section of the 2024 Guide.

I.2.A. Rate Development Standards

I.2.A.i. Compliance with 42 CFR § 438.5(c)

AHCCCS actuaries have followed the rate development standards related to base data in accordance with 42 CFR § 438.5(c). The data types, sources, validation methodologies, material adjustments, and other information related to the documentation standards required by CMS are documented in the subsections of I.2.B.

I.2.B. Appropriate Documentation

I.2.B.i. Data Request

Since AHCCCS employs their own actuaries, a formal data request was not needed between the AHCCCS DBF Actuarial Team and the State. The AHCCCS DBF Actuarial Team worked with the appropriate teams at AHCCCS to obtain the primary sources of data in accordance with 42 CFR § 438.5(c).

I.2.B.ii. Data Used for Rate Development

I.2.B.ii.(a) Description of Data

I.2.B.ii.(a)(i) Types of Data Used

The types of data that AHCCCS relied upon for developing the CYE 24 capitation rates for the ALTCS-EPD Program were:

- Adjudicated and approved encounter data submitted by the ALTCS-EPD Contractors and provided from the AHCCCS Prepaid Medical Management Information System (PMMIS) mainframe
  - Incurred from October 2018 through February 2023
  - Adjudicated and approved through the second encounter cycle in February 2023
- Reinsurance payments made to the ALTCS-EPD Contractors for services
  - Incurred from December 2018 through September 2022 paid through April 2023
- Enrollment data for ALTCS-EPD Contractors from the AHCCCS PMMIS mainframe
  - October 2018 through February 2023
- Annual and quarterly financial statements submitted by the ALTCS-EPD Contractors and reviewed by the AHCCCS DBF Finance & Reinsurance Team
  - October 2018 through December 2022
- AHCCCS Fee-for-Service (FFS) fee schedules developed and maintained by AHCCCS DBF Rates & Reimbursement Team
- Data from AHCCCS DBF Rates & Reimbursement Team related to DAP, see Section I.4.D.
- Data from AHCCCS DBF Financial Analysts related to program changes, see Sections I.2.B.iii.(d) and I.3.B.ii.(a)

Additional sources of data used or reviewed were:

- Supplemental historical and projected data associated with benefit costs, non-benefit costs, and membership provided by the Contractors, including additional detail on claims runout and prior period adjustments included in financial statements
- Adjudicated and approved encounter data from the AHCCCS PMMIS mainframe for use in the Institution for Mental Disease (IMD) analysis, incurred in CYE 22
- Projected CYE 24 enrollment data provided by AHCCCS DBF Budget Team
- Nursing Facility (NF) and Home and Community-Based Settings (HCBS) placement data for October 2018 through February 2023
- Member level share of cost data provided by AHCCCS for October 2018 through September 2022
- Any additional data used and not identified here will be identified in their applicable sections below

I.2.B.ii.(a)(ii) Age of Data

The age of the data are listed above in Section I.2.B.ii.(a)(i).

I.2.B.ii.(a)(iii) Sources of Data

The sources of the data are listed above in Section I.2.B.ii.(a)(i).

I.2.B.ii.(a)(iv) Sub-capitated Arrangements

AHCCCS Contractors sometimes use sub-capitated/block purchasing arrangements for some services. The sub-capitated and block purchasing arrangements between the Contractors and their providers require that the providers submit claims for services provided, which go through the same encounter edit and adjudication process as other claims which are not sub-capitated. These claims come into the system with a CN1 code = 05, which is an indicator for sub-capitated/block purchased encounters, and health plan paid amount equaling zero. After the encounter has been adjudicated and approved, there are repricing methodologies (i.e., formulas) for sub capitated/block purchased encounters to estimate a health plan valued amount in place of the health plan paid amount of zero. Different repricing methodologies have historically been used for different services based on comparisons between total reported medical expenses on the Contractor financial statements and the total encounters available to the actuaries, as submitted through the system for both regular and sub-capitated/block purchased services after completion factors. The units of service data from the encounters and the estimated health plan valued amounts were used for the basis of calculating utilization and unit cost.

I.2.B.ii.(a)(v) Base Data Exception – Not Applicable

Not applicable. No exception to the base data requirements was necessary for capitation rate development.

I.2.B.ii.(b) Availability and Quality of the Data

I.2.B.ii.(b)(i) Data Validation Steps

Guidelines and formats for submitting individual encounters generally follow health insurance industry standards used by commercial insurance companies and Medicare; however, some requirements are specific to the AHCCCS Medicaid program. All encounter submissions are subject to translation and validation using standards and custom business rules (guidelines). Once translation has occurred and the encounters pass validation, they are passed to the AHCCCS PMMIS mainframe and are subject to approximately 500 claims type edits resulting in the approval, denial or pend of each encounter.

The AHCCCS DBF Actuarial Team regularly reviews monthly adjudicated and approved encounters by form type on a cost basis and a PMPM basis looking for anomalous patterns in encounter, unit, or cost totals, such as incurred months where totals are unusually low or high. If any anomalies are found, the AHCCCS DBF Actuarial Team reports the findings to the AHCCCS I Information Services Division (ISD) Data Management and Oversight (DMO) Team, who then works with the Contractors to identify causes. In addition, the AHCCCS ISD DMO Team performs their own checks and validations on the encounters and monitors the number of encounters that are adjudicated and approved each month.

AHCCCS Contractors know encounters are used for capitation rate setting, reconciliations (risk corridors), and reinsurance payments, and thus are cognizant of the importance of timely and accurate encounter submissions. AHCCCS provides the Contractors with the “Encounter Monthly Data File” (aka the “magic” file) which contains the previous 36 months of encounter data. Data fields contained in this file include, but are not limited to, adjudication status, AHCCCS ID, Claim Reference Number (CRN), Provider ID and various cost amounts. The adjudication status has five types: adjudicated/approved, adjudicated/plan denied, adjudicated/AHCCCS denied, pended and adjudicated/void. Generally, the capitation rate setting process only uses the adjudicated/approved encounters but providing this file to the Contractors allows them to compare to their claim payments to identify discrepancies and evaluate the need for new or revised submissions.

All of these processes create confidence in the quality of the encounter data.

I.2.B.ii.(b)(i)(A) Completeness of the Data

The AHCCCS ISD DMO Team performs encounter data validation studies to evaluate the completeness, accuracy, and timeliness of the collected encounter data.

I.2.B.ii.(b)(i)(B) Accuracy of the Data

AHCCCS has an additional encounter process which ensures that each adjudicated and approved encounter contains a valid AHCCCS member ID for an individual who was enrolled on the date that the service was provided. The process also checks to ensure that each adjudicated and approved encounter is for a covered service under the state plan and contains the codes necessary to map it into one of the categories of service used in the rate development process.

The AHCCCS DBF Actuarial Team reviewed the encounter data provided from the AHCCCS PMMIS mainframe. The AHCCCS DBF Actuarial Team ensured that only encounter data with valid AHCCCS

member IDs was used in developing the CYE 24 capitation rates for the ALTCS-EPD Program. Additionally, the AHCCCS DBF Actuarial Team ensured that only services covered under the state plan were included.

I.2.B.ii.(b)(i)(C) Consistency of the Data

The AHCCCS DBF Actuarial Team reviewed the encounter data for all services provided by ALTCS-EPD Contractors to the annual financial statement data for the same entities for CYE 22. The AHCCCS DBF Actuarial Team also compared the CYE 22 encounter data to the yearly supplemental data request from the ALTCS-EPD Contractors. After adjustments were made to the encounter data for completion, the financial statements, the AHCCCS encounter data, and the ALTCS-EPD Contractors' encounter data were judged to be consistent for capitation rate setting.

I.2.B.ii.(b)(ii) Actuaries' Assessment of the Data

As required by ASOP No. 23, the AHCCCS DBF Actuarial Team discloses that the rate development process has relied upon encounter data submitted by the ALTCS-EPD Contractors and provided from the AHCCCS PMMIS mainframe. Additionally, the rate development process has relied upon the audited annual and unaudited quarterly financial statement data submitted by the ALTCS-EPD Contractors and reviewed by the AHCCCS Finance & Reinsurance Team. The AHCCCS DBF Actuarial Team did not audit the data or financial statements and the rate development is dependent upon this reliance. The actuary notes additional reliance on the following:

- data provided by the AHCCCS DBF Rates & Reimbursement Team with regards to DAP and fee schedule impacts,
- data provided by the AHCCCS DBF financial analysts with regard to some program changes,
- information and data provided by Milliman consultants with regard to the HEALTHII program,
- data provided by ALTCS-EPD Contractors in the yearly supplemental data request with regards to administrative and case management component, and
- data provided by the AHCCCS DBF Budget Team with regards to projected enrollment.

The actuary has found the encounter data in total, after adjustments for data concerns, to be appropriate for the purposes of developing the CYE 24 capitation rates for the ALTCS-EPD Program.

I.2.B.ii.(b)(iii) Data Concerns

The AHCCCS DBF Actuarial Team identified an issue with the financial statement reporting of sub-capitated/block purchased service costs, which led to the discovery of an additional issue with the methodologies for repricing sub-capitated/block purchased encounters. The actuary has made a specific adjustment in the development of the capitation rates which addresses the issue for CYE 24 and will be considering different methods for future rate development cycles. Other concerns related to potential fraud, waste, and abuse being included within the encounter data were identified, and specific adjustments to address those concerns have also been made within the rate development process. More detail on these concerns and adjustments are included below in Section I.2.B.iii.(d). There were no other material concerns identified with the availability or quality of the data.

I.2.B.ii.(c) Appropriate Data for Rate Development

The actuary determined that the CYE 22 encounter data in total, after adjustments noted in I.2.B.ii.(b)(iii), was appropriate to use as the base data for developing the CYE 24 capitation rates for the ALTCS-EPD Program.

I.2.B.ii.(c)(i) Not using Encounter or Fee-for-Service Data – Not Applicable

Not Applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 24 capitation rates for the ALTCS-EPD Program.

I.2.B.ii.(c)(ii) Not using Managed Care Encounter Data – Not Applicable

Not applicable. As described above in Section I.2.B.ii.(c), managed care encounters served as the primary data source for the development of the CYE 24 capitation rates for the ALTCS-EPD Program.

I.2.B.ii.(d) Use of a Data Book – Not Applicable

Not applicable. The AHCCCS DBF Actuarial Team did not rely on a data book to develop the CYE 24 capitation rates for the ALTCS-EPD Program.

I.2.B.iii. Adjustments to the Data

This section describes adjustments made to the CYE 22 encounter data that was used as the base data for developing the CYE 24 capitation rates for the ALTCS-EPD Program.

I.2.B.iii.(a) Credibility of the Data – Not Applicable

Not applicable. No credibility adjustments were made to the CYE 22 encounter data.

I.2.B.iii.(b) Completion Factors

The actuary developed completion factors using the development method with monthly encounter data from the Contractors spanning dates of service October 2018 through February 2023 by rate cell and category of service (COS). The completion factors were developed by MCO, major category of service, and month of service. The major categories of service used in ALTCS-EPD completion factor development are primarily based upon the AHCCCS form type, with form A (CMS-1500 professional form type) being further subdivided into HCBS and acute services. Distinct completion factors are therefore developed for the following categories of services: Nursing Facility (LTSS, form type L), HCBS (LTSS, form type A), Acute-Inpatient (non-LTSS, form type I), Acute-Outpatient (non-LTSS, form type O), Acute-Pharmacy (non-LTSS, form type C), and Acute-Other (non-LTSS, form types A and D). The monthly completion factors for CYE 22 were applied to the CYE 22 encounter data.

Aggregate completion factors by rate cell and category of service can be found in Appendix 4. Table 2 below displays the aggregate impact of completion by GSA.

Table 2: Impact of Completion Factors

GSA	Before Completion	After Completion	Impact
Central	$4,247.02	$4,344.32	2.3%
North	$3,312.17	$3,370.93	1.8%
South	$4,041.11	$4,197.14	3.9%
Total	**$4,113.26**	**$4,220.86**	**2.6%**

I.2.B.iii.(c) Errors Found in the Data

No errors were found in the data. Thus, no data adjustments were made for errors.

I.2.B.iii.(d) Changes in the Program

All adjustments to the base data for program and fee schedule changes which occurred during the base period (October 1, 2021, to September 30, 2022) are described below or in Section I.3.A.v. for base data adjustments required with respect to IMD in lieu of services. Adjustments to address the concerns noted by the actuary in Section I.2.B.ii.(b)(iii) are also described in this section. All other program and fee schedule changes which occurred or are effective on or after October 1, 2022, are described in Section I.3.B.ii.(a).

If a base data adjustment change had an impact of 0.2% or less on the gross medical component of the rate for every individual rate cell, that adjustment was deemed non-material and has been grouped in the other base data adjustment subset below.

Some of the impacts for base data adjustment changes described below (indicated by an asterisk *) were developed by AHCCCS DBF financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS Division of Health Care Services (DHCS) Clinical Quality Management (CQM) Team and the Office of the Director's Chief Medical Officer. The actuary relied upon the professional judgment of the AHCCCS DBF financial analysts regarding the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuary met with the AHCCCS DBF financial analysts to understand at a high level how the estimated amounts were derived, and the data used for the amounts. The actuary was unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

Member Share of Cost Add-on

An adjustment was made to add CYE 22 NF and HCBS share of cost (SOC) payments to the base data. This adjustment grosses up the base encounter data to reflect both the provider and member liabilities prior to the application of trend and other prospective adjustments described in Section I.3.B. After application of those adjustments, the projected CYE 24 SOC payments were removed as described in Section I.3.B.ii.(a).

The overall impacts by GSA for the ALTCS-EPD Program are displayed below in Table 3. Totals may not add up due to rounding. The PMPM amounts added by rate cell are included in Appendix 4, column "SOC Payments Added", in the NF and HCBS Expense tables.

Table 3: Member Share of Cost Add-on

GSA	Dollar Impact	PMPM Impact
Central	$31,305,871	$144.52
North	$7,372,797	$251.20
South	$14,805,154	$195.47
Total	**$53,483,822**	**$166.25**

Removal of COVID-19 Tests

As part of monitoring experience throughout the PHE, the AHCCCS DBF Actuarial Team reviewed utilization associated with COVID-19 testing each month. Similar to CYE 23 capitation rate development, this review indicated that it would be more appropriate to model these specific services as a COVID-19 specific adjustment than including the utilization and costs in the base data and proceeding as if no further adjustment would be needed to accurately project costs in the rating period. To that end, as part of the rate development process, all utilization and expenses associated with COVID-19 tests were removed from the base data, as well as from the data used to develop trends, and analyzed separately. The impacts of removing COVID-19 tests are displayed below in Table 4. Totals may not add up due to rounding.

The impact of the specific adjustment for including COVID-19 tests in the rating period is addressed below in Section I.3.B.ii.(a).

Table 4: Removal of COVID-19 tests

GSA	Dollar Impact	PMPM Impact
Central	($581,788)	($2.69)
North	($73,260)	($2.50)
South	($61,366)	($0.81)
Total	**($716,414)**	**($2.23)**

Removal of Differential Adjusted Payments from Base Data

CYE 22 capitation rates funded DAP made from October 1, 2021, through September 30, 2022, to distinguish providers who committed to supporting designated actions that improve the patient care experience, improve member health, and reduce cost of care growth. As these payments expired September 30, 2022, AHCCCS has removed the impact of DAP payments from the base period. To remove the impact, the AHCCCS DBF Actuarial Team requested provider IDs for the qualifying providers for the CYE 22 DAP by specific measure from the AHCCCS Rates & Reimbursement Team. Encounter costs submitted by these providers under DAP provisions during CYE 22 were then adjusted downward by the appropriate percentage bump specific to the DAP measure for the contract year. The associated costs removed from the base data are displayed below in Table 5. Totals may not add up due to rounding. The PMPM amounts removed by rate cell are included in Appendix 4, column “DAP Payments Removed”, in the NF, HCBS, and Acute Expense tables.

See Section I.4.D. for information on adjustments included in CYE 24 capitation rates for DAP that are effective from October 1, 2023, through September 30, 2024.

Table 5: Removal of DAP from Base Data

GSA	Dollar Impact	PMPM Impact
Central	($8,026,241)	($37.05)
North	($1,035,211)	($35.27)
South	($2,759,569)	($36.44)
Total	**($11,821,022)**	**($36.74)**

Removal of Zolgensma

The CYE 22 base data included two administrations of Zolgensma, which is a prescription gene therapy used to treat children under age 2 who are diagnosed with spinal muscular atrophy (SMA). Both recipients were enrolled with the same MCO in the same GSA. As the incidence rate of SMA is very low relative to the enrollment of the ALTCS-EPD Program, AHCCCS does not project any utilization of Zolgensma during the rating period. The relevant encounters were therefore removed from the base data so that those costs would not be included in the projection to CYE 24. The associated reinsurance payments were also removed from the base data used in projecting the reinsurance offset as described in Section I.4.C.ii.(c)(iv). The impact by GSA of removing Zolgensma costs from base data is shown in Table 6.

Table 6: Removal of Zolgensma from Base Data

GSA	Dollar Impact	PMPM Impact
Central	$0	$0.00
North	$0	$0.00
South	($4,403,908)	($58.15)
Total	**($4,403,908)**	**($13.69)**

Sub-capitated/Block Purchase Administrative Expense Removal

During CYE 24 capitation rate setting, the AHCCCS actuaries learned that some non-claims cost dollars which should have been reported as sub-capitated/block purchase administrative expenses per AHCCCS financial reporting guidelines and 42 CFR § 438.8(e)(2)(v)(A) were included in the medical expenses reported in the Contractors' historical financial statements. To adjust for this issue for CYE 24 rate development, the AHCCCS actuaries requested information from the Contractors on the total amounts that should have been reported as sub-capitated/block purchase administrative expenses in CYE 22 and compared those values to the amounts that were reported as sub-capitated/block purchase administrative expenses in CYE 22 to discern the magnitude of the non-claims costs dollars which were included as medical expenses in the CYE 22 financial statements and adjusted the base data for these amounts. The AHCCCS actuaries incorporated a corresponding adjustment to the administrative component to reflect the proper allocation of these expenses in the capitation rates, addressed in Section I.5.B.i.(a) below. The adjustment to remove these expenses from the base data and

subsequently incorporating them into the projected administrative expense, as detailed in I.5.B.i.(a), resolves the data concern the AHCCCS DBF Actuarial Team had with the noted misallocation issue in the financial statement reporting of sub-capitated/block purchase arrangements for the CYE 24 capitation rates.

The impacts to the ALTCS-EPD Program of the sub-capitated/block purchase administrative expense removal from the projected benefit costs are displayed below in Table 7. Totals may not add up due to rounding.

Table 7: Sub-capitated/Block Purchase Administrative Expense Removal

GSA	Dollar Impact	PMPM Impact
Central	($739,035)	($3.41)
North	($116,699)	($3.98)
South	($231,565)	($3.06)
Total	**($1,087,298)**	**($3.38)**

Physician Administered Drugs (PADs) Repricing

Effective October 1, 2023, AHCCCS will implement quarterly rate adjustments for physician administered drugs (PADs) priced using the CMS Average Sales Price (ASP) file, instead of the prior methodology of adjusting once annually to the most recent quarterly ASP file at the same time as other fee schedule changes are made. Consequently, the AHCCCS DBF Actuarial Team has repriced PADs in the base year by taking each quarter's adjudicated and approved encounters with PAD utilization, matching the PADs HCPCS/CPT level data against the quarterly CMS ASP files, and repricing the units to the relevant quarter's ASP rate. The delta between what was paid in the base year, and what would have been paid if this methodology had been in place during the base year, is included as an adjustment to the base data.

The impacts to the ALTCS-EPD Program of repricing historical PAD utilization based on the future quarterly rate adjustment methodology are displayed below in Table 8. Totals may not add up due to rounding.

Table 8: PADs Repricing

GSA	Dollar Impact	PMPM Impact
Central	$130,645	$0.60
North	$458,353	$15.62
South	($6,257)	($0.08)
Total	**$582,741**	**$1.81**

Other Base Data Adjustments

The rate development process includes every individual program change as a separate adjustment. However, as noted earlier in this section, if an individual program change had an impact of 0.2% or less on the gross medical component for every individual rate cell across all GSAs, that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were

aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 9. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in Appendix 4, column "Retrospective Program Changes" in the Acute Expense tables. Brief descriptions of the individual program changes requiring base data adjustment are provided below.

- **Fraud, Waste, and Abuse Adjustment**
  In May 2023, a multi-agency review and investigation of potential fraud, waste, and abuse resulted in the suspension of dozens of providers of Medicaid services based on Credible Allegations of Fraud (CAF). Since that time, there have been additional CAF provider suspensions. The AHCCCS DBF Actuarial team has reviewed MCO encounters, with the exception of H0015 procedure codes, submitted by providers suspended as of June 23, 2023, per the Provider Terminations & Active Suspensions list, for unit cost and quantity characteristics which are substantially different from the characteristics of encounters submitted by providers not identified on the publicly posted CAF list, and adjusted the irregular encounters to bring them into alignment with reasonable utilization and cost patterns. In response to concerns about abusive billing practices using the H0015 procedure code, AHCCCS set a specific fee schedule rate for H0015 in May 2023. Additional information about the development of the impact of the H0015 fee schedule change for all programs is provided below in Section I.3.B.ii.(a). More information about the investigation of potential fraud, waste, and abuse can be found on the AHCCCS website at https://azahcccs.gov/shared/News/PressRelease/PaymentSuspensions.html.
- **Pharmacy and Therapeutics Committee Recommendations – Base Year ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes during CYE22 that impacted utilization and unit costs of Contractors' pharmacy costs in the base period. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.
- **Removal of Covid-19 Vaccine Costs from Base Data**
  As noted above in Section I.1.B.x.(c), there is a separate mechanism to reimburse the Contractor for COVID-19 vaccines on a non-risk basis, so associated costs have been removed from the base encounter data.
- **Reimbursement for Discarded Drugs ***
  Effective January 1, 2022, AHCCCS began requiring Contractors to reimburse discarded amounts of medication products that can only be used once, also known as single use vials.
- **Routine Care for Members Participating in Clinical Trials ***
  AHCCCS will conform with federal guidance that routine care that is otherwise covered be covered for members participating in a clinical research study.
- **N95 Masks ***
  In March 2022, AHCCCS advised Contractors that providers could bill and receive reimbursement for N95 masks issued to members with immunocompromised conditions.

Table 9: Other Base Data Adjustments

GSA	Dollar Impact	PMPM Impact
Central	($53,486)	($0.25)
North	($4,798)	($0.16)
South	($4,871)	($0.06)
Total	**($63,155)**	**($0.20)**

I.2.B.iii.(e) Exclusions of Payments or Services

The AHCCCS DBF Actuarial Team ensured that all non-covered services were excluded from the encounter data used for developing the CYE 24 capitation rates. Other base data adjustments which excluded services from the data (i.e., COVID-19 vaccine removal) are described above in Section I.2.B.iii.(d).

I.3. Projected Benefit Costs and Trends

This section provides documentation for the Projected Benefit Costs and Trends section of the 2024 Guide.

I.3.A. Rate Development Standards

I.3.A.i. Compliance with 42 CFR § 438.3(c)(1)(ii) and 42 CFR § 438.3(e)

The final capitation rates are based only upon services allowed under 42 CFR § 438.3(c)(1)(ii) and 42 CFR § 438.3(e).

I.3.A.ii. Projected Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The actual experience of the covered populations was the primary data source used to develop the projected benefit cost trend assumptions.

I.3.A.iii. In Lieu Of Services or Settings (ILOS)

There are no in lieu of services or settings (ILOS) allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an Institution for Mental Disease (IMD) in lieu of services in an inpatient hospital. For enrollees aged 21 to 64, for inpatient psychiatric or substance use disorder services provided in an IMD setting, the rate development has complied with the requirements of 42 CFR § 438.6(e), and this is described below in Section I.3.A.v.

I.3.A.iv. ILOS Cost Percentage – Not Applicable

Not applicable. There are no ILOS under the ALTCS-EPD Program, except for short term stays in an IMD which are addressed in Section I.3.A.v. below.

I.3.A.v. Institution for Mental Disease

The projected benefit costs include costs for members aged 21-64 that have a stay of no more than 15 cumulative days in a month in an IMD in accordance with 42 CFR § 438.6(e).

Costs Associated with an Institution for Mental Disease Stay

The AHCCCS DBF Actuarial Team adjusted the base data to remove the costs associated with stays in an IMD for enrollees aged 21-64 in accordance with 42 CFR § 438.6(e). The AHCCCS DBF Actuarial Team repriced all utilization of an IMD at the cost of the same services through providers included under the State plan, regardless of length of stay. The AHCCCS DBF Actuarial Team then removed costs for members aged 21-64 for stays in an IMD exceeding 15 cumulative days in a month, whether through a single stay or multiple within the month. Additionally, the AHCCCS DBF Actuarial Team removed all associated medical costs that were provided to the member during the IMD stay(s) that exceeded 15 cumulative days in a month.

The data used to determine the base data adjustment was the CYE 22 encounter data for members who had an institutional stay at an IMD. To identify IMDs within the CYE 22 encounter data, the AHCCCS DBF Actuarial Team relied upon a list of IMDs by the Provider ID, Provider Type ID, and Provider Name. The costs associated with an institutional stay at an IMD were repriced to the non-IMD price-per-day. The

Non-IMD price-per-day used in the analysis was $888.97 and was derived from the CYE 22 encounter data for similar IMD services that occurred within a non-IMD setting. The encounter data was used for the repricing analysis rather than the AHCCCS FFS fee schedule. This was selected because payments made by the health plans better reflect the intensity of the services within a non-IMD setting which may not be fully captured within the AHCCCS FFS fee schedule per diem rate.

The AHCCCS DBF Actuarial Team identified all members aged 21-64 who had IMD stays which exceeded 15 cumulative days in a month and removed from the base data the aggregate repriced amounts of these disallowed stays. If a stay crossed months, only the costs associated with a month in which there were more than 15 cumulative days in a month were removed, in accordance with the guidance from CMS released August 17, 2017 (Q4).

Once a member was identified as having an IMD stay(s) greater than 15 cumulative days in a month, all encounter data for the member was pulled for the timeframe(s) they were in the IMD in order to remove those additional medical service costs from rate development.

The combined impacts of repricing all IMD stays to the cost of the same services through providers included under the State plan, removing IMD stays which exceeded 15 cumulative days in a month, and removing medical expenses related to problematic IMD stays by GSA for the ALTCS-EPD Program are displayed below in Table 10. Totals may not add up due to rounding. The PMPM amounts by rate cell are included in Appendix 4, column "IMD", in the Acute Expense table.

Table 10: IMD Repricing and Removal of All Costs for Repriced Stays > 15 Cumulative Days in a Month

GSA	Dollar Impact	PMPM Impact
Central	$23,237	$0.11
North	($11,323)	($0.39)
South	($29,995)	($0.40)
Total	**($18,081)**	**($0.06)**

I.3.B. Appropriate Documentation

I.3.B.i. Projected Benefit Costs

Appendix 7a contains the projected net medical expenses PMPM by rate cell.

I.3.B.ii. Projected Benefit Cost Development

This section provides information on the projected benefit costs included in the CYE 24 capitation rates for the ALTCS-EPD Program.

I.3.B.ii.(a) Description of the Data, Assumptions, and Methodologies

The base data described in Section I.2.B.ii. was adjusted to reflect completion and all base data adjustments described in Section I.2.B.iii. Further base data adjustments for required IMD changes are described in Section I.3.A.v. The adjusted base data per-member-per-month (PMPM) expenditures for each COS were trended forward 24 months, from the midpoint of the CYE 22 base period to the

midpoint of the CYE 24 rating period. The projected PMPMs were then adjusted for prospective programmatic and fee schedule changes, described below. Appendix 4 contains the base data and base data adjustments by category of service and rate cell. Appendix 5 contains the projected benefit cost trends. Appendix 6 contains net medical expenses by category of service and rate cell after applying prospective program and reimbursement changes, CYE 24 DAP, Projected SOC Payments Removed, and reinsurance offset. Appendix 7a contains projected percentages of members receiving LTSS and projected percentages of LTSS members placed in NF or HCBS settings. Appendix 7b illustrates the capitation rate development, which includes the projected administrative expense, case management expense, underwriting (UW) gain, and premium tax.

The capitation rates were adjusted for all program changes. If a program change had an impact of 0.2% or less on the gross medical component of the rate for every individual rate cell, that program change was deemed non-material and has been grouped in the combined miscellaneous program changes subset below, along with a brief description of the non-material items.

Some of the impacts for projected benefits costs described below (indicated by an asterisk *) were developed by AHCCCS DBF financial analysts, as noted above in Section I.2.B.ii.(b)(ii), with oversight from the AHCCCS DHCS CQM Team and the Office of the Director's Chief Medical Officer. The actuary relied upon the professional judgment of the AHCCCS DBF financial analysts with regards to the reasonableness and appropriateness of the data, assumptions, and methodologies that were used to develop the estimated amounts. The actuary met with the AHCCCS DBF financial analysts to understand at a high level how the estimated amounts were derived and what data was used for the amounts. The actuary was unable to judge the reasonableness of the data, assumptions, and methodologies without performing a substantial amount of additional work.

AHCCCS FFS Fee Schedule Updates

AHCCCS typically makes annual updates to provider fee schedules used for AHCCCS FFS programs. The AHCCCS DBF Rates & Reimbursement Team and the AHCCCS DBF Actuarial Team have typically determined impacts that the change in fees would have on the managed care programs and have applied these impacts to the managed care capitation rates. Although it is not mandated through the health plan contracts except where authorized under applicable law, regulation or waiver, the health plans typically update their provider fee schedules to reflect changes in the AHCCCS provider fee schedules because the health plans tend to benchmark against the AHCCCS provider fee schedules. This information is known through health plan surveys conducted by the AHCCCS DBF Finance & Reinsurance Team regarding health plan fee schedules.

Additionally, the contract has requirements that the Contractors reimburse FQHCs/RHCs at the Prospective Payment System (PPS) rates. The AHCCCS FFS fee schedule updates include adjustments to bring the base FQHC/RHC encounter data up to the projected CYE 24 FQHC/RHC PPS rates.

Effective October 1 of each year, AHCCCS updates provider fee schedules for certain providers based on access to care needs, Medicare/ADHS fee schedule rate changes, and/or legislative mandates. The CYE 24 capitation rates have been adjusted to reflect these fee schedule changes. The AHCCCS DBF Rates &

Reimbursement Team used the CYE 22 encounter data to develop the impacts of fee schedule changes between the base year and the rating period. The AHCCCS DBF Rates & Reimbursement Team applied AHCCCS provider fee schedule changes as a unit cost change to calculate the adjustment to the CYE 22 base data. The AHCCCS DBF Actuarial Team then reviewed the results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting category of service.

Beyond the regular provider fee schedule updates which are effective on October 1 of each year, the October 2022 fee schedule changes incorporated mandated increases for global OBGYN codes and for home and community based services (HCBS) and nursing facility (NF) providers passed by the legislature during the 2022 legislative session, and also increased the All Patients Refined Diagnosis Related Group (APR-DRG) base rate for rural hospitals.

AHCCCS also increases some fee schedule rates effective January 1 of each year to recognize the annual minimum wage increase resulting from the passing of Proposition 206. The increased costs for this change have been included with the fee schedule changes already discussed.

Effective May 1, 2023, AHCCCS set a fixed fee schedule rate for billing code H0015 of $157.86 for one unit of billable service, a change from the prior "by report" rate methodology which paid 58.66% of the billed amount. The AHCCCS DBF Actuarial Team worked with the Contractors to obtain information about which providers would be expected to see changes in their payments or payment structure based on contract status during the base period and/or the rating period. Using that information, the AHCCCS DBF Actuarial Team re-priced H0015 encounter data incurred during the base data year, at the health plan level, for those providers expected to see changes in their payments for the service based on the new fixed fee schedule rate and included the impact of the repricing with the other fee schedule adjustment changes.

The overall impact of the AHCCCS Fee-for-Service fee schedule updates by GSA is illustrated below in Table 11. Totals may not add up due to rounding.

Table 11: Aggregate Fee Schedule Changes

GSA	Dollar Impact	PMPM Impact
Central	$129,228,243	$596.56
North	$15,191,148	$517.57
South	$46,807,457	$618.01
Total	**$191,226,848**	**$594.40**

COVID-19 Tests

As noted above in Section I.2.B.iii.(d), the AHCCCS DBF Actuarial Team has reviewed utilization associated with COVID-19 testing each month. As part of the rate development process, the AHCCCS DBF Actuarial Team modeled projected utilization and costs for COVID-19 tests for the rating period. The projected utilization per 1000 was developed by reviewing utilization, unit costs, and distribution of tests by type during the CYE 22 base period and during the first quarter of CYE 23. The unit cost for different types of COVID-19 tests (lab/physician testing versus at-home test kits) was calculated with

data specific to each type, and the distribution of tests by type provided the blend for an overall projected unit cost in the rating period. Combining projected utilization and unit cost into an overall PMPM for each program, the actuaries then applied utilization and unit cost relativities by each rate cell in the program to the overall PMPM to calculate appropriate PMPM adjustments for each rate cell. This modeling specifically incorporates more recent data than the base period in order to recognize that new variants and reduced public mitigation efforts have impacted the need for COVID-19 testing differently by population. No assumptions regarding vaccination rates were incorporated into the projections for use of tests. The overall impact of the change by GSA is displayed below in Table 12. Totals may not add up due to rounding.

Table 12: COVID-19 Testing

GSA	Dollar Impact	PMPM Impact
Central	$586,435	$2.71
North	$59,404	$2.02
South	$109,317	$1.44
Total	**$755,155**	**$2.35**

Diabetic Drug Class Utilization Changes

Glucagon-like peptide-1 (GLP-1) receptor agonists and sodium-glucose co-transporter-2 inhibitors (SGLT2) play a key role in the treatment of type 2 diabetes mellitus. These drugs may also lead to weight loss, and a reduced need for insulins. The AHCCCS DBF Actuarial Team viewed all historical adjudicated and approved encounters for these drug classes as well as the projected pharmacy trend assumptions to determine if the changing utilization patterns of these drug classes was appropriately accounted for by the trend assumptions, or if a specific adjustment would be more appropriate. After review, the AHCCCS actuaries judged a separate, specific adjustment to be appropriate, except for specific rate cells made up of only Dual eligible members.

The impacts to the ALTCS-EPD Program of the separate, specific adjustments, accounting for the changing utilization of the three diabetic drug classes, are displayed below in Table 13. Totals may not add up due to rounding.

Table 13: Diabetic Drug Class Utilization Change

GSA	Dollar Impact	PMPM Impact
Central	($7,189)	($0.03)
North	$39,852	$1.36
South	$114,079	$1.51
Total	**$146,742**	**$0.46**

Combined Miscellaneous Program Changes

The capitation rates were adjusted for all program changes. However, if an individual program change had an impact of 0.2% or less on the gross medical component of the rate for every individual rate cell,

that program change was deemed non-material for the purpose of the actuarial rate certification. Thus, the impacts were aggregated for the certification by summing the dollar impacts for each non-material adjustment across rate cells within a GSA and dividing through by the projected membership by GSA for the PMPMs listed below. The combined overall impact by GSA is illustrated below in Table 14. Totals may not add up due to rounding. The adjustment factors applied by rate cell are included in the factors shown in Appendix 6, column "Prospective Program Changes" in the HCBS and Acute Expense tables, unless otherwise noted. Brief descriptions of the individual program changes are provided below.

- **Adult Chiropractic Services ***
  Pursuant to HB2863, AHCCCS added chiropractic services ordered by a primary care physician as a covered service for adult members, effective October 1, 2022. Prior to the law, coverage of chiropractic services was limited to children under the age of 21 years.
- **Child Depression Screening ***
  Effective October 1, 2022, the agency revised the AHCCCS Medical Policy Manual (AMPM) 430 to recommend depression and suicide risk screens be provided to children ages 12 to 20 years during EPSDT visits. The change aligned with screening recommendations from the American Academy of Pediatrics.
- **Diabetes Self-Management Training ***
  Pursuant to HB2083, AHCCCS added 10 hours per year of diabetes self-management training as a covered service for diabetic members, effective October 1, 2022.
- **Pharmacy and Therapeutics Committee Recommendations – Post Base Year ***
  On the recommendations of the Pharmacy and Therapeutics (P&T) Committee, AHCCCS adopted policy changes after the base period that are expected to impact the utilization and unit costs of Contractors' pharmacy costs in CYE 24. The P&T Committee evaluates scientific evidence on the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs and reviews how the State can minimize the net cost of pharmaceuticals when considering the value of drug rebates.
- **Unilateral Cochlear Implants ***
  AHCCCS has historically allowed either unilateral or bilateral cochlear devices to be implanted for those with bilateral hearing loss. Based on new research which indicated that this should be expanded to children with unilateral hearing loss, AHCCCS expanded cochlear device coverage to include this group of children effective October 1, 2022.
- **Community Intervener Services ***
  Effective January 1, 2023, AHCCCS established a policy for provision of community intervener services to ALTCS members with dual sensory loss (i.e., blind and hard of hearing). Community interveners intercede between the member and the environment, allowing access to information usually gained through vision and hearing.
- **Dental Cone Beam CT Capture ***
  AHCCCS began reimbursing for cone beam CT capture for dental imaging, effective January 1, 2023. Cone-beam CT capture emits an x-ray beam shaped like a cone as opposed to the conventional fan-shaped beam. This procedure is expected to be used for any tooth extraction as well as for endodontic procedures such as molar and premolar root canals. This type of

imaging would be done in addition to current X-ray imaging. AHCCCS requires prior authorization for fee-for-service coverage of cone beam CT capture.

- **Carvytki ***
  Carvytki is a CAR-T therapy for adult patients, used as treatment for multiple myeloma. It is used after the patient has tried 4 or more other lines of therapy.
  AHCCCS is changing the method of reimbursement for Carvytki from hospital DRG payments to a separately payable service that is reinsurable on its own, similar to other CAR-T drugs. This reimbursement methodology change is expected to enable hospitals to provide this drug.
- **Addition of ALTCS Children to Populations eligible for T1015 billing for Multi-Specialty Independent Clinic (MSIC) Services ***
  Effective October 1, 2023, AHCCCS is expanding the population of children eligible for receiving T1015 (Clinic Visit/Encounter, All-Inclusive) for Multi-Specialty Independent Clinics (MSICs) beyond the current CRS children to include children in the two ALTCS programs. For MSICs, the expansion allows T1015 to be billed in addition to other codes for this expanded population of children.
- **Adolescent SUD Screening ***
  The American Academy of Pediatrics encourages primary care clinicians to follow the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and recommends universal screening for substance use disorder (SUD) for adolescents. Effective October 1, 2023, AHCCCS will offer SUD screening for all 12 to 20 year-olds during EPSDT well-child visits.

Table 14: Combined Miscellaneous Program Changes

GSA	Dollar Impact	PMPM Impact
Central	$572,737	$2.64
North	$60,319	$2.06
South	$211,008	$2.79
Total	**$844,063**	**$2.62**

Projected Member Share of Cost Removal

After application of trend and other prospective adjustments to our base period data described above, the actuary removed projected CYE 24 member SOC payments from the nursing facility and HCBS service categories to reflect only Contractor liability in the capitation rates. The CYE 24 projection for SOC payments was developed by reviewing historical SOC experience (CYE 18 through CYE 22) for consistency in year-over-year increases at the rate cell level, using CPI forecasts to trend the CYE 22 base amount PMPM for SOC forward to CYE 24, and adjusting for any outlier trends.

The overall impact by GSA for the ALTCS-EPD Program is displayed below in Table 15. Totals may not add up due to rounding. The PMPM amounts added by rate cell are included in Appendix 6, column "Projected SOC", in the NF and HCBS Expense tables. Note that these impacts are after application of the percentages for members receiving LTSS and placement in the NF or HCBS settings.

Table 15: Projected Member Share of Cost Removal

GSA	Dollar Impact	PMPM Impact
Central	($36,003,990)	($166.21)
North	($8,444,288)	($287.70)
South	($16,963,181)	($223.97)
Total	**($61,411,459)**	**($190.89)**

I.3.B.ii.(b) Material Changes to the Data, Assumptions, and Methodologies

Any changes to the data, assumptions, or methodologies used to develop the projected benefit costs since the last rating period have been described within the relevant subsections of this certification.

I.3.B.ii.(c) Recoveries of Overpayments to Providers

The ALTCS-EPD Program Contractors are contractually required to adjust or void specific encounters, in full or in part, to reflect recoupments of overpayments to providers. The base data received and used by the actuary to set the CYE 24 capitation rates therefore includes those adjustments.

I.3.B.iii. Projected Benefit Cost Trends

In accordance with 42 CFR § 438.7(b)(2), this section provides documentation on the projected benefit cost trends.

I.3.B.iii.(a) Requirements

I.3.B.iii.(a)(i) Projected Benefit Cost Trends Data

The data used for development of the projected benefit cost trends was the encounter data incurred from October 2018 through early February 2023 and adjudicated and approved through the second February encounter cycle. The trend was developed primarily with actual experience from the Medicaid population.

I.3.B.iii.(a)(ii) Projected Benefit Cost Trends Methodologies

Historical utilization, unit cost, and PMPM data from October 2018 through February 2023 were organized by incurred year and month and category of service (COS). The historical experience was adjusted for completion and normalized for historical program and fee schedule changes. Projected benefit cost trends were developed to project the base data forward 24 months, from the midpoint of CYE 22 (April 1, 2022) to the midpoint of the rating period for CYE 24 (April 1, 2024). Projected benefit cost trends were based on actuarial judgment with consideration of 3-month, 6-month, and 12-month moving averages, and with 12-month, 24-month, and 36-month linear regression results. No simple formulaic solution exists to determine future trend; actuarial judgment is required. Each category of service was analyzed in the same manner.

I.3.B.iii.(a)(iii) Projected Benefit Cost Trends Comparisons

All COS PMPM trend assumptions were compared to similar assumptions made in prior years for ALTCS-EPD capitation rates and judged reasonable to assume for projection to CYE 24.

I.3.B.iii.(a)(iv) Supporting Documentation for Trends

The 2024 Guide requires explanation of outlier or negative trends. As in past years, the AHCCCS DBF Actuarial Team has defined outlier trends as utilization and unit cost trend combinations which resulted in a PMPM trend greater than 7%. There are no outlier or negative trends assumed in the CYE 24 ALTCS-EPD capitation rate development.

I.3.B.iii.(b) Projected Benefit Cost Trends by Component

I.3.B.iii.(b)(i) Changes in Price and Utilization

The trend assumptions were developed by unit cost and utilization. Appendix 5 contains the components of the projected benefit cost trend by risk group and COS.

I.3.B.iii.(b)(ii) Alternative Methods – Not Applicable

Not applicable. The projected benefit cost trends were developed using utilization per 1000 and unit cost components.

I.3.B.iii.(b)(iii) Other Components – Not Applicable

Not applicable. The projected benefit cost trends did not include other components.

I.3.B.iii.(c) Variation in Trend

Projected benefit cost trends do not vary except by risk group and category of service.

I.3.B.iii.(d) Any Other Material Adjustments

There were no other material adjustments made to the projected benefit cost trends.

I.3.B.iii.(e) Any Other Adjustments

There were no other adjustments made to the projected benefit cost trends.

I.3.B.iv. Mental Health Parity and Addiction Equity Act Compliance

AHCCCS has completed a Mental Health Parity and Addiction Equity Act (MHPAEA) analysis and the AHCCCS DHCS Medical Management Team reviews updated Contractor analysis to determine if additional services are necessary to comply with parity standards. As of August 11, 2023, no additional services have been identified as necessary services to comply with MHPAEA.

I.3.B.v. ILOS

There are no ILOS allowed under the contract, except for enrollees aged 21-64 who may receive treatment in an Institution for Mental Disease (IMD) in lieu of services in an inpatient hospital. For inpatient psychiatric or substance use disorder services provided in an IMD setting, the capitation rate development has complied with the requirements of 42 CFR § 438.6(e), and this is described above in Section I.3.A.v.

I.3.B.vi. Retrospective Eligibility Periods

I.3.B.vi.(a) Managed Care Plan Responsibility

AHCCCS provides prior period coverage (PPC) for the period of time prior to the member's enrollment during which the member is eligible for covered services. PPC refers to the time frame from the effective

date of eligibility (usually the first day of the month of application) until the date the member is enrolled with ALTCS-EPD. ALTCS-EPD Contractors receive notification from AHCCCS of the member's enrollment. ALTCS-EPD Contractors are responsible for payment of all claims for medically necessary services covered by ALTCS-EPD and provided to members during PPC.

I.3.B.vi.(b) Claims Data Included in Base Data

Encounter data related to PPC is included with the base data and is included in the capitation rate development process.

I.3.B.vi.(c) Enrollment Data Included in Base Data

Enrollment data related to PPC is included with the base data and is included in the capitation rate development process.

I.3.B.vi.(d) Adjustments, Assumptions, and Methodology

No specific adjustments are made to the CYE 24 capitation rates for the ALTCS-EPD Program for the PPC time frame, given that the encounter and enrollment data are already included within the base data used for capitation rate development.

I.3.B.vii. Impact of All Material Changes to Covered Benefits or Services

This section provides documentation of impacts to projected benefit costs made since the last rate certification.

I.3.B.vii.(a) Covered Benefits

Material adjustments related to covered benefits are discussed in Section I.3.B.ii. of this rate certification.

I.3.B.vii.(b) Recoveries of Overpayments

As noted in Section I.3.B.ii.(c), base period data was not adjusted to reflect recoveries of overpayments made to providers because Contractors are required to adjust encounters for recovery of overpayments, per the following contract requirement:

> "The Contractor shall void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters shall be submitted."

I.3.B.vii.(c) Provider Payment Requirements

Material adjustments related to provider payment requirements under State Directed Payments are discussed in Section I.4.D of this rate certification. Additionally, provider payment requirements related to FQHCs/RHCs are described in Section I.3.B.ii.

I.3.B.vii.(d) Applicable Waivers

There were no material changes since the last rate certification related to waiver requirements or conditions.

I.3.B.vii.(e) Applicable Litigation

There were no material adjustments made related to litigation.

I.3.B.viii. Impact of All Material and Non-Material Changes

All material and non-material changes have been included in the capitation rate development process and all requirements in this section of the 2024 Guide are documented in Section I.3.B.ii.(a) above.

I.4. Special Contract Provisions Related to Payment

I.4.A. Incentive Arrangements

I.4.A.i. Rate Development Standards

An incentive arrangement, as defined in 42 CFR § 438.6(a), is any payment mechanism under which a health plan may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract.

I.4.A.ii. Appropriate Documentation

I.4.A.ii.(a) Description of Any Incentive Arrangements

Alternative Payment Model Initiative – Performance Based Payments

The CYE 24 capitation rates for the ALTCS-EPD Program include an incentive arrangement, as described under 42 CFR § 438.6(b)(2), called the APM Initiative – Performance Based Payments. The APM Initiative – Performance Based Payments incentive arrangement is a special provision for payment where the Contractors may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractors that are aimed at quality improvement such as reducing costs, improving health outcomes, or improving access to care.

Alternative Payment Model Initiative – Quality Measure Performance

The incentive arrangement for the APM Initiative – Quality Measure Performance is a special provision for payment where Contractors may receive additional funds over and above the capitation rates for performance on a select subset of AHCCCS performance measures. An incentive pool is determined by the portion of the withhold described below that is not returned to the Contractors under the terms of the withhold arrangement. The incentive arrangement uses a ranked score to distribute available incentive dollars by AHCCCS performance measure, but Contractors will not be ranked if they did not earn either a performance achievement score or a performance improvement score for that measure. The maximum incentive pool possible is approximately $17.3 million, which is the amount that would be available if every Contractor earned exactly 0% of the withhold described below. This is not anticipated to happen; thus, the incentive pool will be determined by the portion of the withhold which is not earned across all Contractors.

I.4.A.ii.(a)(i) Time Period

The time period of the incentive arrangements described herein is twelve months.

I.4.A.ii.(a)(ii) Enrollees, Services, and Providers Covered

Alternative Payment Model Initiative – Performance Based Payments

All enrollees, children and adults, may be covered by this incentive arrangement. Likewise, all network providers have the opportunity to participate in the APM arrangements and all covered services are eligible for inclusion. The Contractors' provider contracts must include performance measures for quality and/or cost effectiveness. The Contractors are mandated to utilize the APM strategies in the

Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 as defined at https://hcp-lan.org/workproducts/apm-whitepaper.pdf.

Alternative Payment Model Initiative – Quality Measure Performance

The incentive arrangement includes performance measures impacting comprehensive diabetes care, cervical cancer screening, and breast cancer screening. All adult and child enrollees utilizing the services addressed in the performance measures, and providers of these services, are covered by the incentive arrangement, unless specifically stated otherwise in contract or policy.

I.4.A.ii.(a)(iii) Purpose

Alternative Payment Model Initiative – Performance Based Payments

The purpose of the APM Initiative – Performance Based Payments incentive arrangement is to align incentives between the Contractors and providers to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality to achieve cost savings and quantifiably improved outcomes.

Alternative Payment Model Initiative – Quality Measure Performance

The purpose of the APM Initiative – Quality Measure Performance incentive arrangement is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings.

I.4.A.ii.(a)(iv) Attestation to Limit on Incentive Payments

The total payments under the incentive arrangements for the ALTCS-EPD Program (i.e., capitation rate payments plus incentive payments) will not exceed 105% of the capitation payments to comply with 42 CFR § 438.6(b)(2).

I.4.A.ii.(a)(v) Effect on Capitation Rate Development

Alternative Payment Model Initiative – Performance Based Payments

Incentive payments for the APM Initiative – Performance Based Payments incentive arrangement are not included in the CYE 24 capitation rates and had no effect on the development of the capitation rates for the ALTCS-EPD Program. The incentive payments will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the CYE 24 contract year.

Alternative Payment Model Initiative – Quality Measure Performance

Incentive payments for the APM Initiative – Quality Measure Performance incentive arrangement are not included in the CYE 24 capitation rates and had no effect on the development of the capitation rates for the ALTCS-EPD Program. Incentive payments will be paid by AHCCCS to the Contractors through lump sum payments after the completion of the contract year and the computation of the performance measures, and after the withhold payments are distributed and the value of the incentive pool determined.

I.4.B. Withhold Arrangements

I.4.B.i. Rate Development Standards

This section of the 2024 Guide provides information on the definition and requirements of a withhold arrangement.

I.4.B.ii. Appropriate Documentation

I.4.B.ii.(a) Description of Any Withhold Arrangements

The ALTCS-EPD Program includes a percentage of capitation withhold arrangement which the Contractor may earn back. Each Contractor's earnings are based on their performance achievement score, using a threshold benchmark and a high-performance benchmark, and/or performance improvement score by measure.

I.4.B.ii.(a)(i) Time Period

The time period of the withhold arrangement described herein is twelve months.

I.4.B.ii.(a)(ii) Enrollees, Services, and Providers Covered

All enrollees, services and providers are covered by this withhold arrangement unless specifically stated otherwise in contract or policy.

I.4.B.ii.(a)(iii) Purpose of the Withhold

The purpose of the ALTCS-EPD Program withhold is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings.

I.4.B.ii.(a)(iv) Description of Percentage of Capitation Rates Withheld

AHCCCS has established a quality withhold of 1% of the Contractor's capitation and a percentage (up to 100%) of the withheld amount will be paid to the Contractor for performance on select performance measures. AHCCCS will determine the portion of the withheld amount to be returned based on a review of each Contractor's data and the Contractor's compliance with these performance measures.

I.4.B.ii.(a)(v) Percentage of the Withheld Amount Not Reasonably Achievable

It is unlikely that a Contractor will not receive some portion of the withhold back. However, the AHCCCS DBF Actuarial Team does not have the information needed to develop an estimate of the withheld amount that is not reasonably achievable, as a new policy governing the performance measure results became effective October 1, 2022, for CYE 23 and forward. The DBF Actuarial Team expects to have the first estimate of withhold not reasonably achievable under the new policy in the summer of 2025.

I.4.B.ii.(a)(vi) Description of Reasonableness of Withhold Arrangement

The actuary relied upon the AHCCCS DBF Finance & Reinsurance Team's review. Their review indicated that the total withhold percentage of 1% of capitation revenue does not have a detrimental impact on the Contractors' financial operating needs and capital reserves. The AHCCCS DBF Finance & Reinsurance Team's interpretation of financial operating needs relates to cash flow needs for the Contractors to pay claims and administer benefits for its covered populations. The AHCCCS DBF Finance & Reinsurance

Team evaluated the reasonableness of the withhold within this context by reviewing the Contractors' cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by AHCCCS. To evaluate the reasonableness of the withhold in relation to capitalization levels, the AHCCCS DBF Finance & Reinsurance Team reviewed the surplus above the equity per member requirement, the performance bond amounts, and the financial stability of each Contractor to pay all obligations. The AHCCCS DBF Finance & Reinsurance Team reviewed cash and cash equivalent levels in relation to the withhold arrangement and has indicated the withhold arrangement is reasonable based on current cash levels.

I.4.B.ii.(a)(vii) Effect on Capitation Rate Development

The capitation rates shown in this rate certification are illustrated before offset for the withhold amount. The withhold amount is not considered within capitation rate development.

I.4.B.ii.(b) Certifying Rates less Expected Unachieved Withhold as Actuarially Sound

The CYE 24 capitation rates documented in this rate certification are actuarially sound even if none of the withhold is earned back.

I.4.C. Risk-Sharing Mechanisms

I.4.C.i. Rate Development Standards

This section of the 2024 Guide provides information on the requirements for risk-sharing mechanisms. For information on the COVID-19 costs covered on a non-risk basis, see Section I.1.B.x.(c).

In accordance with 42 CFR § 438.6(b)(1), all risk-sharing mechanisms have been developed in accordance with 42 CFR § 438.4, the rate development standards in 42 CFR § 438.5, and generally accepted actuarial principles and practices. Additionally, all risk-sharing mechanisms are documented in the contract and capitation rate certification for the rating period which will be submitted to CMS before the start of the rating period and will not be modified or added after the start of the rating period.

I.4.C.ii. Appropriate Documentation

I.4.C.ii.(a) Description of Risk-Sharing Mechanisms

The CYE 24 contract for the ALTCS-EPD Program will include risk corridors.

I.4.C.ii.(a)(i) Rationale for Risk-Sharing Mechanisms

AHCCCS has a long-standing program policy of including risk corridors within the managed care programs to protect the State against excessive Contractor profits, and to protect Contractors from excessive losses. This risk sharing arrangement also contributes to Contractor sustainability and program continuity, which is an additional intangible benefit to the stability of the Medicaid member. The CYE 24 contract will continue AHCCCS' long-standing program policy and will include risk corridors. This rate certification will use the term risk corridor to be consistent with the 2024 Guide. The ALTCS-EPD Contract refers to the risk corridor as a reconciliation.

I.4.C.ii.(a)(ii) Description of Risk-Sharing Mechanism Implementation

There are two risk corridor type arrangements in the ALTCS-EPD Program. The first is a reconciliation of actual SOC payments to assumed SOC offsets in the capitation rates, and the second is a reconciliation of costs to reimbursement (tiered reconciliation).

The share of cost (SOC) risk corridor will reconcile the actual member share of cost (SOC) payments received by each Contractor during each contract year against the PMPM amounts assumed in the capitation rates for that year. The SOC payments are reconciled to zero; that is, payments to, or recoupments from, each Contractor are the arithmetic difference between the actual and assumed amounts, grossed up by 2% for premium tax.

The tiered risk corridor will reconcile each Contractor's medical cost expenses to the net capitation paid to each Contractor. Net capitation is equal to the capitation rates paid less the administrative component, the case management component, and the premium tax, plus any reinsurance payments. Each Contractor's medical cost expenses are equal to the Contractor's fully adjudicated encounters (excluding COVID-19 vaccine expenses for CYE 24) and sub-capitated/block purchase medical expenses as reported by the Contractor's financial statements with dates of service during the contract year. Initial reconciliations are typically performed no sooner than 6 months after the end of the contract year and final reconciliations are typically computed no sooner than 15 months after the contract year. This risk corridor will limit each ALTCS-EPD Contractor's statewide profits and losses as listed in Table 16 below.

Table 16: Tiered Risk Corridor Risk Bands

Profit	MCO Share	State Share	Max MCO Profit	Cumulative MCO Profit
<= 2%	100%	0%	2%	2%
> 2% and <= 6%	50%	50%	2%	4%
> 6%	0%	100%	0%	4%
Loss	**MCO Share**	**State Share**	**Max MCO Loss**	**Cumulative MCO Loss**
<= 2%	100%	0%	2%	2%
> 2%	0%	100%	0%	2%

Additional information regarding the CYE 24 risk corridors can be found in the Compensation section of the ALTCS-EPD Program contract.

I.4.C.ii.(a)(iii) Effect of Risk-Sharing Mechanisms on Capitation Rates

The risk corridors did not have any effect on the development of the CYE 24 capitation rates for the ALTCS-EPD Program.

I.4.C.ii.(a)(iv) Development in Accordance with Generally Accepted Actuarial Principles and Practices

Risk-sharing mechanisms are developed in accordance with generally accepted actuarial principles and practices. The threshold amounts for the risk corridors was set using actuarial judgment with

consideration of conversations between the AHCCCS DBF Actuarial Team, the AHCCCS DBF Finance & Reinsurance Team, and the AHCCCS Office of the Director.

I.4.C.ii.(a)(v) Risk-Sharing Arrangements Consistent with Pricing Assumptions

The inclusion of risk corridors as part of the contract is independent of the pricing assumptions used in capitation rate development. If the contract did not include risk corridors, the pricing assumptions used in capitation rate development would be unchanged.

Please see Section I.4.C.ii.(c) for documentation of reinsurance risk-sharing arrangements and the resulting impacts on capitation rate development.

I.4.C.ii.(a)(vi) Expected Remittance/Payment from Risk-Sharing Arrangements

If experience in the rating period aligns with pricing assumptions used in capitation rate development, there will be no remittance/payment between AHCCCS and the Contractors associated with the risk corridors. The risk corridors protect the State against excessive Contractor profits and protect Contractors from excessive losses when experience in the rating period materially differs from the pricing assumptions. For the medical costs, there is no remittance/payment when profits and losses associated with medical costs compared to medical revenue are between the first +/- 2%, as shown in the table in Section I.4.C.ii.(a)(ii), which is consistent with pricing assumptions used in capitation rate development.

See Section I.4.C.ii.(c) for reinsurance risk-sharing arrangements.

I.4.C.ii.(b) Remittance/Payment Requirements for Specified Medical Loss Ratio – Not Applicable

Not applicable. The ALTCS-EPD Program contract does not include a medical loss ratio remittance or payment requirement.

I.4.C.ii.(c) Reinsurance Requirements

I.4.C.ii.(c)(i) Description of Reinsurance Requirements

AHCCCS provides a reinsurance program to the AHCCCS Contractors for the partial reimbursement of covered medical services incurred during the contract year. This reinsurance program is similar to what is seen in commercial reinsurance programs with a few differences. The deductible is lower than a standard commercial reinsurance program. AHCCCS has different reinsurance case types, with the majority of the reinsurance cases falling into the Regular reinsurance case type. Regular reinsurance cases cover partial reimbursement (anything above the deductible and the coinsurance percentage amounts) of inpatient facility medical services. Most of the other reinsurance cases fall under Catastrophic, including reinsurance for biologic drugs. Additionally, rather than the ALTCS-EPD Contractors paying a premium, the capitation rates are instead adjusted by subtracting the reinsurance offset from the gross medical. One could view the reinsurance offset as a premium. Historical encounter data and reinsurance payments are used as the base for development of the reinsurance offset.

The AHCCCS reinsurance program has been in place since 1982 and is funded with State Match and Federal Matching authority. AHCCCS is self-insured for the reinsurance program, which is characterized

by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS reimburses the ALTCS-EPD Contractors for covered services incurred above the deductible. The deductible is the responsibility of the ALTCS-EPD Contractors. The deductible for CYE 24 Regular reinsurance cases is $150,000, an increase from the CYE 23 Regular reinsurance case deductible. The limit on High Dollar Catastrophic reinsurance is $1,000,000. Once a reinsurance case hits this limit, the Contractor is reimbursed 100% for all medically necessary covered expenses. All reinsurance deductibles are applied at the member level.

The actual reinsurance case amounts are paid to the ALTCS-EPD Contractors whether the actual amount is above or below the reinsurance offset in the capitation rates. This can result in a loss or gain by each ALTCS-EPD Contractor based on actual reinsurance payments versus expected reinsurance payments.

For additional information on the reinsurance program, refer to the Reinsurance section of the ALTCS-EPD Program contract.

I.4.C.ii.(c)(ii) Effect on Development of Capitation Rates

The reinsurance offset (expected PMPM of reinsurance payments for the rate setting period) is subtracted from the gross medical PMPM calculated for the rate setting period. It is a separate calculation and does not affect the methodologies for development of the gross medical component of the capitation rates.

I.4.C.ii.(c)(iii) Development in Accordance with Generally Accepted Actuarial Principles and Practices

Projected reinsurance offsets are developed in accordance with generally accepted actuarial principles and practices.

I.4.C.ii.(c)(iv) Data, Assumptions, Methodology to Develop the Reinsurance Offset

The methodology for setting the reinsurance offset has not changed from the CYE 23 capitation rates. The reinsurance offsets by rate cell are developed from CYE 22 reinsurance payments to the ALTCS-EPD Contractors for Regular and Catastrophic reinsurance cases associated with services incurred during the base period. The data is "brought current" by way of completion factors specific to reinsurance payments, adjustments for historical and prospective program and reimbursement changes, and has the same trend factors applied as the gross medical expense for acute care services, since LTSS expenses are not eligible for consideration in reinsurance. The PMPM expense trend assumed for the Acute – Inpatient COS is applied to payments for Regular reinsurance cases; the Acute – Pharmacy PMPM expense trend is applied to payments for the biologic case type; and the aggregate PMPM expense trend for all Acute services is applied to payments for Catastrophic reinsurance cases. The reinsurance payments associated with the two Zolgensma cases were removed from the base reinsurance payment data, consistent with removal of the encounters from the development of gross medical expenses as described in Section I.2.B.iii.(d).

Changes to the reinsurance program from the CYE 22 base period to the CYE 24 rating period include updated drug coverage under the biologic reinsurance case type and increasing the deductible for Regular reinsurance cases to $150,000 as noted above. The projected costs of the additional drugs

covered by the reinsurance program were calculated by taking the projected costs for CYE 24 for those drugs and applying a zero-dollar deductible and coinsurance limit of 85% to get the dollar impact to the reinsurance offset. The adjustments needed to reflect the higher deductible level for the Regular reinsurance case type were developed by calculating the total encounter costs associated with each Regular reinsurance case for which payments were made during CYE 22; applying completion factors, trend, and fee schedule changes to bring the encounter costs forward to the CYE 24 rating year; and calculating the reinsurance payments that would be made for each case when applying the new $150,000 deductible and the coinsurance limit of 75%.

I.4.D. State Directed Payments

I.4.D.i. Rate Development Standards

This section of the 2024 Guide provides information on delivery system and provider payment initiatives (i.e., state directed payments) authorized under 42 CFR § 438.6(c).

I.4.D.ii. Appropriate Documentation

I.4.D.ii.(a) Description of State Directed Payments

The only state directed payments addressed in this certification are the ones related to the ALTCS-EPD Program. The contract requires the adoption of a minimum fee schedule for FQHC/RHC providers using State plan approved rates, as defined in 42 CFR § 438.6(a), as allowed under 42 CFR § 438.6(c)(1)(iii)(A). This state directed payment for FQHC/RHC providers does not require written approval prior to implementation per 42 CFR § 438.6(c)(2)(ii). The state directed payments which require preprints for prior approval are DAP, APSI, PSI, HEALTHII, and NF-SP. The 2024 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

I.4.D.ii.(a)(i) Type and Description of Directed Payment Arrangements

Federally Qualified Health Centers and Rural Health Clinics

Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Medicaid State plan as a minimum fee schedule for FQHC/RHC providers. The Medicaid State plan describes the methodology for the calculation of PPS rates in Attachment 4.19-B starting on Page 3a.

Differential Adjusted Payments

The DAP initiative delivers a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP. The potential rate increases range from 0.5% to 20.0%, depending on the provider type.

Access to Professional Services Initiative

The APSI provides a uniform percentage increase of 75% to otherwise contracted rates for eligible practitioners, critical to professional training and education efforts, who deliver services to AHCCCS members. The uniform percentage increase is applicable only to services covered under the AHCCCS APSI policy. The rate increase is intended to supplement, not supplant, payments to eligible providers.

Pediatric Services Initiative

The PSI provides a uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 licensed beds. The PSI uniform percentage increase is based on a fixed total payment amount and is expected to fluctuate based on utilization in the contract year. The increase is intended to supplement, not supplant, payments to eligible hospitals or pediatric units.

Hospital Enhanced Access Leading to Health Improvements Initiative

The HEALTHII delivers a uniform percentage increase to hospitals for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The HEALTHII uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class's aggregate targeted pay-to-cost ratio for Medicaid Managed care services. The increase is intended to supplement, not supplant, payments to eligible providers.

Nursing Facility Supplemental Payments

The NF-SP delivers a uniform dollar increase across all Contractors' reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund, plus FMAP, and is expected to fluctuate based on utilization and available funds for each quarter. The increase is intended to supplement, not supplant, payments to eligible providers.

I.4.D.ii.(a)(ii) Directed Payments Incorporated in Capitation Rates

The FQHC/RHC minimum fee schedule and the DAP initiative are the only directed payments incorporated in the capitation rates. The 2024 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

I.4.D.ii.(a)(ii)(A) Rate Cells Affected

The FQHC/RHC minimum fee schedule and DAP initiative state directed payments impact all ALTCS-EPD rate cells.

I.4.D.ii.(a)(ii)(B) Impact on the Rate Cells

The FQHC/RHC minimum fee schedule impact is included as part of the aggregate fee schedule changes shown in Appendix 6. See Appendix 8b for the total impact by rate cell for the FQHC/RHC minimum fee schedule. For DAP, see Appendix 6 for medical impact by rate cell and Appendix 8b for total impact by rate cell.

I.4.D.ii.(a)(ii)(C) Data, Assumptions, Methodology to Develop Directed Payment Adjustment

Federally Qualified Health Centers and Rural Health Clinics

The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates, described above in Section I.3.B.ii.(a).

Differential Adjusted Payments

The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 22 encounter data across all

programs for the providers who qualify for DAP. The AHCCCS DBF Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 24 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and risk group to the applicable categories of service to come to the final dollar impact for CYE 24 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DBF Actuarial Team then aggregated to the specific risk groups for each program).

I.4.D.ii.(a)(ii)(D) Preprint Acknowledgement

AHCCCS has submitted the DAP 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates were certified. The DAP payment arrangement accounted for in the capitation rates, and described in the preceding sections, is included in the capitation rates in a manner consistent with the preprint under CMS review.

I.4.D.ii.(a)(ii)(E) Maximum Fee Schedule – Not Applicable

Not applicable. None of the directed payments for the ALTCS-EPD Program are based on maximum fee schedules.

I.4.D.ii.(a)(iii) Directed Payments Under Separate Payment Arrangement

The APSI, PSI, HEALTHII, and NF-SP are not included in the ALTCS-EPD certified capitation rates and will be paid out via lump sum payments. The 2024 Guide requires a specifically formatted table in addition to the information provided here. This CMS prescribed table can be found in Appendix 8a.

I.4.D.ii.(a)(iii)(A) Aggregate Amount

Access to Professional Services Initiative

Anticipated payments, including premium tax, for APSI are approximately $4.80 million. AHCCCS will distribute the total payment via four quarterly lump sum payments equal to 20% of the estimated amount to the Contractors, and a final lump sum payment after the completion of the contract year which will equal the difference between the quarterly payments and the actual annual rate increase calculated based on encounter data for the contract year.

Pediatric Services Initiative

Anticipated payments, including premium tax, for PSI are approximately $2.46 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 24 utilization will be used to redistribute the payments.

Hospital Enhanced Access Leading to Health Improvements Initiative

Anticipated payments, including premium tax, for HEALTHII are approximately $62.34 million. AHCCCS will distribute the total payment via four interim quarterly lump sum payments to the Contractors. After the completion of the contract year, CYE 24 utilization will be used to redistribute the payments.

Nursing Facility Supplemental Payments

The anticipated payments, including premium tax, for NF-SP are approximately $95.86 million. AHCCCS will distribute the total payment via four quarterly lump sum payments to the Contractors. Quarterly lump sum payments will be based on the current available funds in the nursing facility assessment fund plus FMAP.

I.4.D.ii.(a)(iii)(B) Actuarial Certification of the Amount of the Separate Payment Term

Access to Professional Services Initiative

The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from estimates based on actual utilization, and once final amounts are known, a notification document will be sent to CMS with that information.

Pediatric Services Initiative

The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from estimates based on actual utilization, and once final amounts are known, a notification document will be sent to CMS with that information.

Hospital Enhanced Access Leading to Health Improvements Initiative

The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from estimates based on actual utilization, and once final amounts are known, a notification document will be sent to CMS with that information.

Nursing Facility Supplemental Payments

The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4. These estimates are based on projections of future events. The actual payments will differ from estimates based on actual utilization, and once final amounts are known, a notification document will be sent to CMS with that information.

I.4.D.ii.(a)(iii)(C) Estimated Impact by Rate Cell

Appendix 8b contains estimated PMPMs, including premium tax, by rate cell for informational purposes only; these payments are not made on a PMPM basis.

I.4.D.ii.(a)(iii)(D) Preprint Acknowledgement

Access to Professional Services Initiative

AHCCCS has submitted the APSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Pediatric Services Initiative

AHCCCS has submitted the PSI 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Hospital Enhanced Access Leading to Health Improvements Initiative

AHCCCS has submitted the HEALTHII 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

Nursing Facility Supplemental Payments

AHCCCS has submitted the NF-SP 42 CFR § 438.6(c) preprint to CMS but has not yet received approval. The actuary received and reviewed each state directed payment preprint at the time the rates were certified. The payment arrangement is accounted for in a manner consistent with the preprint that is under CMS review.

I.4.D.ii.(a)(iii)(E) Future Documentation Requirements

Access to Professional Services Initiative

After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Pediatric Services Initiative

After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Hospital Enhanced Access Leading to Health Improvements Initiative

After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Nursing Facility Supplemental Payments

After the rating period is complete and the final NF-SP payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NF-SP payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state

directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

I.4.D.ii.(b) Confirmation of No Other Directed Payments

There are not any additional directed payments in the program that are not addressed in the rate certification, including minimum fee schedules using State plan approved rates as defined in 42 CFR § 438.6(a).

I.4.D.ii.(c) Confirmation Regarding Required Reimbursement Rates

There are not any requirements regarding reimbursement rates the plans must pay to providers unless specifically specified in the certification as a state directed payment or authorized under applicable law, regulation, or waiver.

I.4.E. Pass-Through Payments – Not Applicable

Not applicable. There are no pass-through payments for the ALTCS-EPD Program.

I.5. Projected Non-Benefit Costs

I.5.A. Rate Development Standards

This section of the 2024 Guide provides information on the non-benefit component of the capitation rates.

I.5.B. Appropriate Documentation

I.5.B.i. Description of the Development of Projected Non-Benefit Costs

I.5.B.i.(a) Data, Assumptions, Methodology

The primary data sources used to develop the administrative component of the CYE 24 capitation rates for the EPD Program was the historical and projected administrative expense data submitted by the Contractors per a supplemental data request, as noted in Section I.2.B.ii.(b)(ii). The Contractors' projected administrative expense estimates for CYE 24 were reviewed to inform development of cost projections. The ALTCS-EPD Contractors' supplemental administrative data request included amounts for administrative expenses for CYE 22 actuals, CYE 23 Q1 (through December 31, 2022) actuals, actual/projected amounts for CYE 23, and projected amounts for CYE 24. This data request included administrative breakouts into different categories for each of the time frames. The actuary also reviewed Consumer Price Index (CPI) and Employment Cost Index (ECI) data from S&P Global Market Intelligence Healthcare Cost Review and each Contractor's quarterly financial statements for CYE 22 and CYE 23 Q1.

Administrative Expenses

The actuary used CYE 22 administrative (Admin) expenses reported in the MCOs' supplemental non-benefit cost data submission as the base experience for projecting CYE 24 Admin expenses.

The wage-driven portion of the CYE 22 Admin expenses was trended forward from the base period to the rating period by the projected CPI for wage earners. The trend factor was based on data from an external firm, S&P Global Market Intelligence Healthcare Cost Review, which was reviewed and determined to be reasonable. A trend factor was not applied to the non-wage-driven portion of the CYE 22 Admin expenses.

The CYE 24 projected wage-driven and non-wage driven and amounts, summed together, equal the projected CYE 24 Admin expenses.

As described in Section I.2.B.iii.(d), non-claims costs removed from the base data were incorporated into the projected administrative expense after applying two years of wage inflation as an additional adjustment.

Case Management Expenses

The actuary used CYE 22 case management expenses reported in the MCOs' quarterly financial statements as the base experience for projecting CYE 24 Case Management expenses. The actuary also evaluated each MCO's non-benefit cost data submission for reasonableness to make MCO-specific adjustments in developing the final case management expense.

Additional adjustments were then made for the change in HCBS mix percentage from the base experience period to the rating period and to increase the wage-driven portion of the base case management expenses by the projected CPI for wage earners (as described in the Admin section above).

I.5.B.i.(b) Changes from the Previous Rate Certification

The data, assumptions, and methodology used to develop the CYE 24 projected administrative and case management costs are similar to the previous rating period and have been documented above. The previous methodology is documented in the CYE 23 actuarial rate certification.

I.5.B.i.(c) Any Other Material Changes

No other material adjustments were applied to the projected non-benefit expenses included in the capitation rate.

I.5.B.ii. Projected Non-Benefit Costs by Category

The projected non-benefit costs for each of the listed categories of costs in the 2024 Guide are shown in Appendix 7 for the CYE 24 capitation rates.

I.5.B.ii.(a) Administrative Costs

The administrative component of the CYE 24 ALTCS-EPD capitation rates is described above in Section I.5.B.i.(a). The PMPM amounts by rate cell are provided in Appendix 7b.

I.5.B.ii.(b) Taxes and Other Fees

The CYE 24 capitation rates for the ALTCS-EPD Program include a provision for premium tax of 2.0% of capitation. The premium tax is applied to the total capitation. No other taxes, fees, or assessments are applicable for this filing.

I.5.B.ii.(c) Contribution to Reserves, Risk Margin, and Cost of Capital

The CYE 24 capitation rates for the ALTCS-EPD Program include an increased provision (denoted as underwriting (UW) gain and expressed as a percentage) for contributions to reserves, risk margin, and cost of capital, compared to the CYE 23 capitation rates UW gain assumption. The increase is primarily attributable to changes in the cost of capital, particularly in the year since the previous capitation rate development cycle. Additionally, while the unwinding of the PHE is unlikely to have significant impacts on the acuity of the population for the ALTCS-EPD Program as discussed elsewhere, the PHE itself significantly increased the observed HCBS mix percentage due to mortality within nursing homes, and while the recent HCBS/NF placement levels are similar to those seen before the PHE and may represent a new equilibrium, it will require care on the part of the Contractors to ensure that the pendulum doesn't continue swinging toward the more costly institutional settings. The third contributor to the increased risk margin can also be indirectly attributed to the PHE, with shorter and milder seasons for influenza and other respiratory viruses during the pandemic, but with the end of the declaration of the PHE, there is the risk that these illnesses will resurge in the rating period. For CYE 24, the actuary has built in a provision of 1.45% for the UW gain to address the changes listed above.

I.5.B.ii.(d) Other Material Non-Benefit Costs

No other material or non-material non-benefit costs are reflected in the CYE 24 capitation rates for the ALTCS-EPD Program.

I.5.B.iii. Historical Non-Benefit Cost

Historical non-benefit cost data is provided by the AHCCCS Contractors via financial statements and additional data requests. The audited financial statements can be found on the AHCCCS website at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/contractedhealthplan.html. Historical non-benefit cost data was considered and used in the non-benefit cost assumptions as described in section I.5.B.i.(a) above.

I.6. Risk Adjustment – Not Applicable

Not applicable. The CYE 24 capitation rates for the ALTCS-EPD Program do not include risk adjustment.

I.7. Acuity Adjustments – Not Applicable

Not applicable. The CYE 24 capitation rate for the ALTCS-EPD Program does not utilize acuity adjustments.

Section II Medicaid Managed Care Rates with Long-Term Services and Supports

Section II of the 2024 Guide is applicable to the ALTCS-EPD Program because the CYE 24 capitation rates for ALTCS-EPD are subject to the applicable "actuarial soundness" provisions from 42 CFR § 438.4 and the ALTCS-EPD Program includes managed long-term services and supports (MLTSS).

II.1. Managed Long-Term Services and Supports

II.1.A. CMS Expectations

The rate development standards and appropriate documentation described in Section I of the 2024 Guide are applicable to the MLTSS rate development process.

II.1.B. Rate Development Standards

II.1.B.i. Rate Cell Structure

This section of the 2024 Guide provides the two most common approaches to structuring the rate cells.

II.1.B.i.(a) Blended Capitation Rate

The monthly capitation rate for each rate cell is developed as a blended rate payable for each enrolled member.

II.1.B.i.(b) Non-Blended Capitation Rate – Not Applicable

Not applicable. A member's long-term care setting does not determine the capitation paid for that member.

II.1.C. Appropriate Documentation

II.1.C.i. Considerations

II.1.C.i.(a) Rate Cell Structure

The monthly capitation rate for each rate cell is developed as a blended rate payable for each enrolled member.

II.1.C.i.(b) Data, Assumptions, Methodologies

Data, assumptions, and methodologies used for the development of projected gross medical expenses administrative expenses, and case management expenses are described above in Sections I.3 and I.5.

II.1.C.i.(c) Other Payment Structures, Incentives, or Disincentives

There are no other payment structures, incentives, or disincentives to pay ALTCS-EPD Contractors other than what has already been described above in Sections I.4.A and I.4.C.

II.1.C.i.(d) Effect of MLTSS on Utilization and Unit Cost

The ALTCS-EPD Program operates as managed care. No data is available that would quantify the impacts of care management on utilization or unit costs.

II.1.C.i.(e) Effect of MLTSS on Setting of Care

The ALTCS-EPD Program operates as managed care. No data is available that quantifies the effect that the management of this care is expected to have on the level of care within each care setting.

II.1.C.ii. Projected Non-Benefit Costs

The development of projected non-benefit costs is described in Section I.5.B of this certification.

II.1.C.iii. Additional Information

No additional information beyond the types and sources of data described in Section I.2.B.ii of this certification was considered.

Section III New Adult Group Capitation Rates – Not Applicable

Section III of the 2024 Guide is not applicable to the ALTCS-EPD Program. As noted in Section I.1.B.iii, all covered populations under the ALTCS-EPD Program receive the regular FMAP.

Appendix 1: Actuarial Certification

I, Matthew C. Varitek, FSA, MAAA, am an employee of AHCCCS. I meet the qualification standards established by the American Academy of Actuaries and have followed generally accepted actuarial practices and regulatory requirements, including published guidance from the American Academy of Actuaries, the Actuarial Standards Board, CMS, and federal regulations.

The capitation rates included with this rate certification are considered actuarially sound according to the following criteria from 42 CFR § 438.4(a) and 42 CFR § 438.4(b). The state did not opt to develop capitation rate ranges, therefore adherence to 42 CFR § 438.4(c) is not required.

- § 438.4(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.
- § 438.4(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:
- § 438.4(b)(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations. Any differences in the assumptions, methodologies, or factors used to develop capitation rates must not vary with the rate of Federal financial participation (FFP) associated with the covered populations in a manner that increases Federal costs. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PIHPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations. CMS may require a State to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or the covered populations.
- § 438.4(b)(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- § 438.4(b)(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.
- § 438.4(b)(4) Be specific to payments for each rate cell under the contract.
- § 438.4(b)(5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- § 438.4(b)(6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
- § 438.4(b)(7) Meet any applicable special contract provisions as specified in § 438.6.
- § 438.4(b)(8) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.

- § 438.4(b)(9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

Additionally, the term actuarially sound is defined in Actuarial Standard of Practice (ASOP) 49, "Medicaid Managed Care Capitation Rate Development and Certification," as:

> "Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes."

The data, assumptions, and methodologies used to develop the CYE 24 capitation rates for the ALTCS-EPD Program have been documented according to the guidelines established by CMS in the 2024 Guide. The CYE 24 capitation rates for the ALTCS-EPD Program are effective from October 1, 2023, through September 30, 2024.

The actuarially sound capitation rates are based on projections of future events. Actual results may vary from the projections. In developing the actuarially sound capitation rates, I have relied upon data and information provided by AHCCCS and ALTCS-EPD Contractors. I have relied upon AHCCCS and ALTCS-EPD Contractors for the accuracy of the data and we have accepted the data without audit, after checking the data for reasonableness and consistency unless stated otherwise.

SIGNATURE ON FILE — August 11, 2023

Matthew C. Varitek — Date
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Appendix 2: Certified Capitation Rates

Appendix 2: Certified Capitation Rates

GSA	Contractor	Dual	Non-Dual
North	UnitedHealthcare	$3,947.09	$7,778.43
Central	UnitedHealthcare	$3,812.33	$8,565.72
Central	Banner - University Family Care	$5,049.50	$10,512.84
Central	Mercy Care	$5,069.23	$10,339.34
South	Banner - University Family Care	$4,944.20	$9,341.25
South	Mercy Care	$4,866.12	$8,745.28

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

Appendix 3: Fiscal Impact Summary and Comparison to Prior Rates

Rate Cell	Contractor	GSA	CYE 24 Projected MMs	CYE 23 Capitation Rate	CYE 24 Capitation Rate	Projected Expenditures CYE 23	Projected Expenditures CYE 24	Percentage Change
Dual	UnitedHealthcare	North	25,191	$3,739.84	$3,947.09	$94,209,722	$99,430,450	5.54%
Dual	UnitedHealthcare	Central	65,125	$3,668.48	$3,812.33	$238,909,169	$248,277,278	3.92%
Dual	Banner - University Family Care	Central	25,337	$4,820.91	$5,049.50	$122,146,077	$127,937,760	4.74%
Dual	Mercy Care	Central	84,649	$4,894.91	$5,069.23	$414,351,212	$429,107,662	3.56%
Dual	Banner - University Family Care	South	43,056	$4,615.57	$4,944.20	$198,728,251	$212,877,894	7.12%
Dual	Mercy Care	South	21,214	$4,483.34	$4,866.12	$95,111,117	$103,231,575	8.54%
Non-Dual	UnitedHealthcare	North	4,160	$8,303.46	$7,778.43	$34,541,649	$32,357,589	(6.32%)
Non-Dual	UnitedHealthcare	Central	11,218	$8,569.16	$8,565.72	$96,125,052	$96,086,434	(0.04%)
Non-Dual	Banner - University Family Care	Central	5,749	$10,486.45	$10,512.84	$60,282,626	$60,434,357	0.25%
Non-Dual	Mercy Care	Central	24,547	$10,049.40	$10,339.34	$246,679,106	$253,796,091	2.89%
Non-Dual	Banner - University Family Care	South	7,492	$8,698.31	$9,341.25	$65,170,200	$69,987,300	7.39%
Non-Dual	Mercy Care	South	3,977	$8,615.91	$8,745.28	$34,263,435	$34,777,901	1.50%
Dual		**Composite**	**264,572**	**$4,397.50**	**$ 4,614.48**	**$1,163,455,548**	**$1,220,862,619**	**4.93%**
Non-Dual		**Composite**	**57,142**	**$9,398.76**	**$ 9,580.37**	**$537,062,069**	**$547,439,671**	**1.93%**
Total		**Composite**	**321,714**	**$5,285.81**	**$ 5,496.50**	**$1,700,517,617**	**$1,768,302,290**	**3.99%**

Appendix 4: Base Data and Base Data Adjustments

Appendix 4: Base Data and Base Data Adjustments

Appendix 4a. Nursing Facility

				I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Contractor	GSA	Rate Cell	Category of Service	Uncompleted Gross Total	Completion Factors	Completed PMPM	SOC Payments Added	Subtotal	COVID-19 Test Removal	DAP Payments Removed	Zolgensma Removal	Subcap Admin Removal	PAD Repricing	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
UnitedHealthcare	North	Dual	NF	$5,313.40	0.987	$5,381.86	$936.02	$6,317.89	0.00%	(1.46%)	0.00%	0.00%	0.00%	0.00%	0.00%	$6,225.93
UnitedHealthcare	Central	Dual	NF	$6,104.05	0.987	$6,182.70	$868.86	$7,051.56	0.00%	(1.46%)	0.00%	0.00%	0.00%	0.00%	0.00%	$6,948.54
Banner - University Family Care	Central	Dual	NF	$6,309.59	0.952	$6,624.96	$871.92	$7,496.89	0.00%	(1.43%)	0.00%	0.00%	0.00%	0.00%	0.00%	$7,389.86
Mercy Care	Central	Dual	NF	$6,672.92	0.983	$6,789.12	$743.81	$7,532.92	0.00%	(1.47%)	0.00%	0.00%	0.00%	0.00%	0.00%	$7,422.54
Banner - University Family Care	South	Dual	NF	$6,350.00	0.952	$6,667.39	$796.53	$7,463.92	0.00%	(1.21%)	0.00%	0.00%	0.00%	0.00%	0.00%	$7,373.26
Mercy Care	South	Dual	NF	$5,532.56	0.983	$5,628.90	$753.30	$6,382.20	0.00%	(1.39%)	0.00%	0.00%	0.00%	0.00%	0.00%	$6,293.22
UnitedHealthcare	North	Non-Dual	NF	$8,679.94	0.987	$8,791.78	$79.76	$8,871.54	0.00%	(1.73%)	0.00%	0.00%	0.00%	0.00%	0.00%	$8,718.28
UnitedHealthcare	Central	Non-Dual	NF	$9,213.91	0.987	$9,332.63	$64.77	$9,397.39	0.00%	(1.65%)	0.00%	0.00%	0.00%	0.00%	0.00%	$9,242.80
Banner - University Family Care	Central	Non-Dual	NF	$9,286.76	0.952	$9,750.94	$77.32	$9,828.26	0.00%	(1.66%)	0.00%	0.00%	0.00%	0.00%	0.00%	$9,665.36
Mercy Care	Central	Non-Dual	NF	$10,515.97	0.983	$10,699.09	$93.53	$10,792.61	0.00%	(1.57%)	0.00%	0.00%	0.00%	0.00%	0.00%	$10,622.75
Banner - University Family Care	South	Non-Dual	NF	$8,297.58	0.952	$8,712.32	$108.90	$8,821.22	0.00%	(1.44%)	0.00%	0.00%	0.00%	0.00%	0.00%	$8,694.33
Mercy Care	South	Non-Dual	NF	$8,025.17	0.983	$8,164.91	$146.69	$8,311.61	0.00%	(1.66%)	0.00%	0.00%	0.00%	0.00%	0.00%	$8,173.73

Appendix 4: Base Data and Base Data Adjustments

Appendix 4b. Home and Community Based Services

				I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Contractor	GSA	Rate Cell	Category of Service	Uncompleted Gross Total	Completion Factors	Completed PMPM	SOC Payments Added	Subtotal	COVID-19 Test Removal	DAP Payments Removed	Zolgensma Removal	Subcap Admin Removal	PAD Repricing	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
UnitedHealthcare	North	Dual	HCBS	$1,689.84	0.979	$1,726.23	$20.85	$1,747.09	0.00%	(0.22%)	0.00%	0.00%	0.00%	0.00%	0.00%	$1,743.30
UnitedHealthcare	Central	Dual	HCBS	$1,894.11	0.979	$1,934.91	$15.98	$1,950.89	0.00%	(0.24%)	0.00%	0.00%	0.00%	0.00%	0.00%	$1,946.28
Banner - University Family Care	Central	Dual	HCBS	$2,286.10	0.964	$2,372.46	$28.89	$2,401.34	0.00%	(0.26%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,395.02
Mercy Care	Central	Dual	HCBS	$2,556.42	0.993	$2,573.41	$28.05	$2,601.46	0.00%	(0.33%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,592.87
Banner - University Family Care	South	Dual	HCBS	$2,194.79	0.964	$2,277.69	$15.74	$2,293.43	0.00%	(0.32%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,286.19
Mercy Care	South	Dual	HCBS	$2,543.82	0.993	$2,560.73	$34.30	$2,595.03	0.00%	(0.28%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,587.70
UnitedHealthcare	North	Non-Dual	HCBS	$1,707.25	0.979	$1,744.02	$7.78	$1,751.80	0.00%	(0.26%)	0.00%	0.00%	0.00%	0.00%	(0.02%)	$1,746.97
UnitedHealthcare	Central	Non-Dual	HCBS	$2,102.97	0.979	$2,148.27	$4.12	$2,152.39	0.00%	(0.27%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,146.48
Banner - University Family Care	Central	Non-Dual	HCBS	$2,372.23	0.964	$2,461.84	$0.70	$2,462.54	0.00%	(0.27%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,455.94
Mercy Care	Central	Non-Dual	HCBS	$2,895.80	0.993	$2,915.05	$8.38	$2,923.43	0.00%	(0.35%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,913.31
Banner - University Family Care	South	Non-Dual	HCBS	$2,130.87	0.964	$2,211.36	$7.97	$2,219.32	0.00%	(0.32%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,212.21
Mercy Care	South	Non-Dual	HCBS	$2,944.85	0.993	$2,964.43	$9.32	$2,973.75	0.00%	(0.31%)	0.00%	0.00%	0.00%	0.00%	0.00%	$2,964.40

Appendix 4: Base Data and Base Data Adjustments

Appendix 4c. Acute

				I.2.B.ii	I.2.B.iii.(b)	Subtotal	I.2.B.iii.(d)	Subtotal	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.2.B.iii.(d)	I.3.A.v	Total
Contractor	GSA	Rate Cell	Category of Service	Uncompleted Gross Total	Completion Factors	Completed PMPM	SOC Payments Added	Subtotal	COVID-19 Test Removal	DAP Payments Removed	Zolgensma Removal	Subcap Admin Removal	PAD Repricing	Other Base Data Adjustments	IMD	Adjusted Base Gross Medical
UnitedHealthcare	North	Dual	Acute	$166.18	0.974	$170.66	$0.00	$170.66	(0.36%)	(0.57%)	0.00%	(1.51%)	0.00%	0.04%	0.10%	$166.77
UnitedHealthcare	Central	Dual	Acute	$222.71	0.976	$228.28	$0.00	$228.28	(0.56%)	(0.46%)	0.00%	(1.57%)	0.00%	(0.01%)	0.10%	$222.60
Banner - University Family Care	Central	Dual	Acute	$336.22	0.917	$366.59	$0.00	$366.59	(0.03%)	(0.53%)	0.00%	(1.37%)	0.00%	0.01%	0.00%	$359.54
Mercy Care	Central	Dual	Acute	$437.92	0.961	$455.82	$0.00	$455.82	(0.18%)	(0.42%)	0.00%	(0.12%)	0.00%	0.01%	0.01%	$452.63
Banner - University Family Care	South	Dual	Acute	$231.65	0.916	$252.95	$0.00	$252.95	(0.00%)	(0.65%)	0.00%	(0.95%)	0.00%	0.04%	(0.17%)	$248.58
Mercy Care	South	Dual	Acute	$278.73	0.960	$290.48	$0.00	$290.48	(0.25%)	(0.48%)	0.00%	(0.08%)	0.00%	0.02%	0.02%	$288.23
UnitedHealthcare	North	Non-Dual	Acute	$2,901.22	0.978	$2,966.11	$0.00	$2,966.11	(0.46%)	(0.72%)	0.00%	(0.41%)	3.71%	(0.05%)	(0.12%)	$3,022.53
UnitedHealthcare	Central	Non-Dual	Acute	$3,473.60	0.978	$3,552.06	$0.00	$3,552.06	(0.37%)	(0.80%)	0.00%	(0.44%)	(0.12%)	(0.05%)	0.01%	$3,489.85
Banner - University Family Care	Central	Non-Dual	Acute	$3,338.10	0.928	$3,597.91	$0.00	$3,597.91	(0.20%)	(0.83%)	0.00%	(0.53%)	0.22%	(0.00%)	0.01%	$3,550.23
Mercy Care	Central	Non-Dual	Acute	$3,863.11	0.968	$3,992.87	$0.00	$3,992.87	(0.25%)	(0.73%)	0.00%	(0.05%)	0.14%	(0.04%)	(0.00%)	$3,955.54
Banner - University Family Care	South	Non-Dual	Acute	$3,659.64	0.932	$3,924.89	$0.00	$3,924.89	(0.13%)	(0.97%)	(14.97%)	(0.48%)	0.02%	(0.01%)	(0.05%)	$3,283.57
Mercy Care	South	Non-Dual	Acute	$2,553.59	0.968	$2,638.48	$0.00	$2,638.48	(0.12%)	(0.64%)	0.00%	(0.06%)	(0.13%)	(0.09%)	0.02%	$2,611.71

Appendix 5: Projected Benefit Cost Trends

Appendix 5: Projected Benefit Cost Trends

		I.3.B.iii.	I.3.B.iii.	
GSA	COS	Utilization per 1000	Unit Cost	PMPM
Central	NF	0.0%	2.0%	2.0%
Central	HCBS - Assisted Living	3.5%	2.0%	5.6%
Central	HCBS - Attendant Care	1.0%	0.0%	1.0%
Central	HCBS - Other	1.0%	0.0%	1.0%
Central	Acute - Inpatient	1.0%	0.0%	1.0%
Central	Acute - Outpatient	1.0%	0.0%	1.0%
Central	Acute - Other	0.0%	2.0%	2.0%
Central	Acute - Physician	0.0%	2.0%	2.0%
Central	Acute - Pharmacy	1.0%	3.5%	4.5%
Greater Arizona	NF	1.0%	1.0%	2.0%
Greater Arizona	HCBS - Assisted Living	1.5%	2.0%	3.5%
Greater Arizona	HCBS - Attendant Care	1.5%	0.0%	1.5%
Greater Arizona	HCBS - Other	0.0%	0.0%	0.0%
Greater Arizona	Acute - Inpatient	2.0%	0.0%	2.0%
Greater Arizona	Acute - Outpatient	2.0%	0.0%	2.0%
Greater Arizona	Acute - Other	0.0%	2.0%	2.0%
Greater Arizona	Acute - Physician	0.0%	2.0%	2.0%
Greater Arizona	Acute - Pharmacy	0.0%	3.5%	3.5%

Appendix 6: Development of Gross Medical Component

Appendix 6: Development of Gross Medical Component

Appendix 6a. Nursing Facility

				Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.4.D	Subtotal	I.3.B.ii.(a)	I.4.C.ii.(c)	Total
Contractor	GSA	Rate Cell	Category of Service	Adjusted Base PMPM	Trend	Aggregate Fee Schedule Changes	COVID-19 Testing	Diabetes Drug Class Changes	Other Projected Program Changes	DAP Add In	Subtotal	Projected SOC	Reinsurance	Net Projected Medical
UnitedHealthcare	North	Dual	NF	$6,225.93	2.01%	14.46%	0.00%	0.00%	0.00%	1.69%	$7,541.41	($1,070.78)	$0.00	$6,470.63
UnitedHealthcare	Central	Dual	NF	$6,948.54	2.00%	14.47%	0.00%	0.00%	0.00%	1.71%	$8,416.50	($1,000.20)	$0.00	$7,416.30
Banner - University Family Care	Central	Dual	NF	$7,389.86	2.00%	14.46%	0.00%	0.00%	0.00%	1.78%	$8,956.87	($973.95)	$0.00	$7,982.93
Mercy Care	Central	Dual	NF	$7,422.54	2.00%	14.47%	0.00%	0.00%	0.00%	1.81%	$8,999.74	($891.02)	$0.00	$8,108.72
Banner - University Family Care	South	Dual	NF	$7,373.26	2.01%	14.47%	0.00%	0.00%	0.00%	1.49%	$8,913.36	($913.43)	$0.00	$7,999.93
Mercy Care	South	Dual	NF	$6,293.22	2.01%	14.47%	0.00%	0.00%	0.00%	1.35%	$7,597.00	($861.36)	$0.00	$6,735.64
UnitedHealthcare	North	Non-Dual	NF	$8,718.28	2.01%	14.47%	0.00%	0.00%	0.00%	1.85%	$10,577.17	($121.38)	$0.00	$10,455.79
UnitedHealthcare	Central	Non-Dual	NF	$9,242.80	2.00%	14.47%	0.00%	0.00%	0.00%	1.91%	$11,217.00	($84.02)	$0.00	$11,132.98
Banner - University Family Care	Central	Non-Dual	NF	$9,665.36	2.00%	14.47%	0.00%	0.00%	0.00%	1.86%	$11,724.27	($90.41)	$0.00	$11,633.86
Mercy Care	Central	Non-Dual	NF	$10,622.75	2.00%	14.47%	0.00%	0.00%	0.00%	1.89%	$12,889.23	($109.33)	$0.00	$12,779.90
Banner - University Family Care	South	Non-Dual	NF	$8,694.33	2.01%	14.47%	0.00%	0.00%	0.00%	1.61%	$10,522.53	($140.39)	$0.00	$10,382.14
Mercy Care	South	Non-Dual	NF	$8,173.73	2.01%	14.47%	0.00%	0.00%	0.00%	1.46%	$9,878.31	($169.50)	$0.00	$9,708.81

Appendix 6: Development of Gross Medical Component

Appendix 6b. Home and Community Based Services

				Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.4.D	Subtotal	I.3.B.ii.(a)	I.4.C.ii.(c)	Total
Contractor	GSA	Rate Cell	Category of Service	Adjusted Base PMPM	Trend	Aggregate Fee Schedule Changes	COVID-19 Testing	Diabetes Drug Class Changes	Other Projected Program Changes	DAP Add In	Subtotal	Projected SOC	Reinsurance	Net Projected Medical
UnitedHealthcare	North	Dual	HCBS	$1,743.30	2.48%	17.93%	0.00%	0.00%	0.00%	1.36%	$2,188.66	($22.48)	$0.00	$2,166.18
UnitedHealthcare	Central	Dual	HCBS	$1,946.28	3.57%	17.90%	0.00%	0.00%	0.00%	1.15%	$2,489.81	($17.69)	$0.00	$2,472.11
Banner - University Family Care	Central	Dual	HCBS	$2,395.02	3.78%	17.89%	0.00%	0.00%	0.00%	1.56%	$3,088.43	($19.96)	$0.00	$3,068.47
Mercy Care	Central	Dual	HCBS	$2,592.87	2.80%	17.73%	0.00%	0.00%	0.00%	1.86%	$3,285.69	($29.94)	$0.00	$3,255.74
Banner - University Family Care	South	Dual	HCBS	$2,286.19	2.16%	17.92%	0.00%	0.00%	0.00%	2.45%	$2,882.45	($19.45)	$0.00	$2,863.00
Mercy Care	South	Dual	HCBS	$2,587.70	2.16%	17.70%	0.00%	0.00%	0.00%	1.90%	$3,238.86	($36.57)	$0.00	$3,202.29
UnitedHealthcare	North	Non-Dual	HCBS	$1,746.97	1.96%	17.49%	0.00%	0.00%	0.01%	1.94%	$2,175.63	($9.55)	$0.00	$2,166.07
UnitedHealthcare	Central	Non-Dual	HCBS	$2,146.48	2.88%	17.62%	0.00%	0.00%	0.00%	1.62%	$2,715.63	($3.47)	$0.00	$2,712.16
Banner - University Family Care	Central	Non-Dual	HCBS	$2,455.94	3.18%	17.15%	0.00%	0.00%	0.00%	2.00%	$3,124.13	($3.57)	$0.00	$3,120.56
Mercy Care	Central	Non-Dual	HCBS	$2,913.31	1.82%	16.77%	0.00%	0.00%	0.00%	2.32%	$3,608.66	($7.19)	$0.00	$3,601.47
Banner - University Family Care	South	Non-Dual	HCBS	$2,212.21	1.69%	17.41%	0.00%	0.00%	0.07%	3.30%	$2,776.43	($5.01)	$0.00	$2,771.42
Mercy Care	South	Non-Dual	HCBS	$2,964.40	1.40%	16.59%	0.00%	0.00%	0.06%	2.94%	$3,660.16	($5.59)	$0.00	$3,654.57

Appendix 6: Development of Gross Medical Component

Appendix 6c. Acute

				Appendix 4	Appendix 5	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.3.B.ii.(a)	I.4.D	Subtotal	I.3.B.ii.(a)	I.4.C.ii.(c)	Total
Contractor	GSA	Rate Cell	Category of Service	Adjusted Base PMPM	Trend	Aggregate Fee Schedule Changes	COVID-19 Testing	Diabetes Drug Class Changes	Other Projected Program Changes	DAP Add In	Subtotal	Projected SOC	Reinsurance	Net Projected Medical
UnitedHealthcare	North	Dual	Acute	$166.77	2.02%	0.04%	0.28%	0.00%	1.07%	0.02%	$176.03	$0.00	($2.52)	$173.51
UnitedHealthcare	Central	Dual	Acute	$222.60	1.87%	0.03%	0.43%	0.00%	0.64%	0.02%	$233.58	$0.00	($31.19)	$202.39
Banner - University Family Care	Central	Dual	Acute	$359.54	1.86%	0.01%	0.08%	0.00%	0.71%	0.01%	$376.08	$0.00	($4.12)	$371.95
Mercy Care	Central	Dual	Acute	$452.63	1.83%	0.00%	0.15%	0.00%	0.69%	0.01%	$473.37	$0.00	($29.12)	$444.25
Banner - University Family Care	South	Dual	Acute	$248.58	2.04%	0.00%	0.01%	0.00%	0.94%	0.01%	$261.32	$0.00	($4.28)	$257.04
Mercy Care	South	Dual	Acute	$288.23	2.02%	0.06%	0.22%	0.00%	0.83%	0.00%	$303.39	$0.00	$0.00	$303.39
UnitedHealthcare	North	Non-Dual	Acute	$3,022.53	2.53%	2.51%	0.34%	0.29%	0.09%	0.80%	$3,306.69	$0.00	($517.35)	$2,789.34
UnitedHealthcare	Central	Non-Dual	Acute	$3,489.85	2.54%	1.44%	0.29%	0.05%	0.08%	0.83%	$3,768.37	$0.00	($605.62)	$3,162.76
Banner - University Family Care	Central	Non-Dual	Acute	$3,550.23	2.27%	1.62%	0.46%	(0.13%)	0.08%	0.92%	$3,823.20	$0.00	($351.50)	$3,471.70
Mercy Care	Central	Non-Dual	Acute	$3,955.54	2.47%	1.42%	0.22%	0.00%	0.08%	0.79%	$4,258.12	$0.00	($493.91)	$3,764.20
Banner - University Family Care	South	Non-Dual	Acute	$3,283.57	2.28%	2.04%	0.31%	0.19%	0.09%	1.16%	$3,567.03	$0.00	($112.62)	$3,454.42
Mercy Care	South	Non-Dual	Acute	$2,611.71	2.44%	1.81%	0.11%	0.58%	0.12%	0.73%	$2,832.98	$0.00	($27.58)	$2,805.40

Appendix 7: Capitation Rate Development

Appendix 7a: Capitation Rate Development

					I.3.B.ii.(a)	I.3.B.ii.(a)	Appendix 6	Total
Contractor	GSA	Rate Cell	Category of Service	Projected Member Months	Projected Percent Members Receiving LTSS	Projected Mix	Net Projected Medical	Total Net Medical
UnitedHealthcare	North	Dual	Nursing Facility		97.43%	30.1%	$6,470.63	$1,895.70
UnitedHealthcare	North	Dual	Home and Community Based Services		97.43%	69.9%	$2,166.18	$1,475.81
UnitedHealthcare	North	Dual	Acute			100.0%	$173.51	$173.51
UnitedHealthcare	North	Dual	Total	25,191	97.43%	100.0%		$3,545.02
UnitedHealthcare	Central	Dual	Nursing Facility		97.13%	17.0%	$7,416.30	$1,221.91
UnitedHealthcare	Central	Dual	Home and Community Based Services		97.13%	83.0%	$2,472.11	$1,993.79
UnitedHealthcare	Central	Dual	Acute			100.0%	$202.39	$202.39
UnitedHealthcare	Central	Dual	Total	65,125	97.13%	100.0%		$3,418.09
Banner - University Family Care	Central	Dual	Nursing Facility		98.73%	23.1%	$7,982.93	$1,823.24
Banner - University Family Care	Central	Dual	Home and Community Based Services		98.73%	76.9%	$3,068.47	$2,328.80
Banner - University Family Care	Central	Dual	Acute			100.0%	$371.95	$371.95
Banner - University Family Care	Central	Dual	Total	25,337	98.73%	100.0%		$4,523.99
Mercy Care	Central	Dual	Nursing Facility		97.77%	20.5%	$8,108.72	$1,625.15
Mercy Care	Central	Dual	Home and Community Based Services		97.77%	79.5%	$3,255.74	$2,530.69
Mercy Care	Central	Dual	Acute			100.0%	$444.25	$444.25
Mercy Care	Central	Dual	Total	84,649	97.77%	100.0%		$4,600.09
Banner - University Family Care	South	Dual	Nursing Facility		98.90%	26.5%	$7,999.93	$2,098.67
Banner - University Family Care	South	Dual	Home and Community Based Services		98.90%	73.5%	$2,863.00	$2,080.56
Banner - University Family Care	South	Dual	Acute			100.0%	$257.04	$257.04
Banner - University Family Care	South	Dual	Total	43,056	98.90%	100.0%		$4,436.26
Mercy Care	South	Dual	Nursing Facility		98.27%	27.7%	$6,735.64	$1,831.16
Mercy Care	South	Dual	Home and Community Based Services		98.27%	72.3%	$3,202.29	$2,276.44
Mercy Care	South	Dual	Acute			100.0%	$303.39	$303.39
Mercy Care	South	Dual	Total	21,214	98.27%	100.0%		$4,410.99
UnitedHealthcare	North	Non-Dual	Nursing Facility		95.07%	26.7%	$10,455.79	$2,657.86
UnitedHealthcare	North	Non-Dual	Home and Community Based Services		95.07%	73.3%	$2,166.07	$1,508.68
UnitedHealthcare	North	Non-Dual	Acute			100.0%	$2,789.34	$2,789.34
UnitedHealthcare	North	Non-Dual	Total	4,160	95.07%	100.0%		$6,955.88
UnitedHealthcare	Central	Non-Dual	Nursing Facility		94.93%	23.8%	$11,132.98	$2,518.46
UnitedHealthcare	Central	Non-Dual	Home and Community Based Services		94.93%	76.2%	$2,712.16	$1,961.15
UnitedHealthcare	Central	Non-Dual	Acute			100.0%	$3,162.76	$3,162.76
UnitedHealthcare	Central	Non-Dual	Total	11,218	94.93%	100.0%		$7,642.37
Banner - University Family Care	Central	Non-Dual	Nursing Facility		94.79%	34.0%	$11,633.86	$3,753.39
Banner - University Family Care	Central	Non-Dual	Home and Community Based Services		94.79%	66.0%	$3,120.56	$1,951.09
Banner - University Family Care	Central	Non-Dual	Acute			100.0%	$3,471.70	$3,471.70
Banner - University Family Care	Central	Non-Dual	Total	5,749	94.79%	100.0%		$9,176.17
Mercy Care	Central	Non-Dual	Nursing Facility		94.58%	27.3%	$12,779.90	$3,300.53
Mercy Care	Central	Non-Dual	Home and Community Based Services		94.58%	72.7%	$3,601.47	$2,476.09
Mercy Care	Central	Non-Dual	Acute			100.0%	$3,764.20	$3,764.20
Mercy Care	Central	Non-Dual	Total	24,547	94.58%	100.0%		$9,540.82
Banner - University Family Care	South	Non-Dual	Nursing Facility		96.64%	28.1%	$10,382.14	$2,820.38
Banner - University Family Care	South	Non-Dual	Home and Community Based Services		96.64%	71.9%	$2,771.42	$1,925.47
Banner - University Family Care	South	Non-Dual	Acute			100.0%	$3,454.42	$3,454.42
Banner - University Family Care	South	Non-Dual	Total	7,492	96.64%	100.0%		$8,200.26
Mercy Care	South	Non-Dual	Nursing Facility		96.59%	29.3%	$9,708.81	$2,751.90
Mercy Care	South	Non-Dual	Home and Community Based Services		96.59%	70.7%	$3,654.57	$2,494.04
Mercy Care	South	Non-Dual	Acute			100.0%	$2,805.40	$2,805.40
Mercy Care	South	Non-Dual	Total	3,977	96.59%	100.0%		$8,051.35

Appendix 7b: Capitation Rate Development

			Appendix 7a	I.5.B.i.	I.5.B.i.	I.5.B.ii.(c)	Calculation	I.5.B.ii.(b)	Total
Rate Cell	Contractor	GSA	Total Net Medical	Case Management	Admin PMPM	UW Gain Percent	UW Gain PMPM	Premium Tax	Capitation Rate PMPM
Dual	UnitedHealthcare	North	$3,545.02	$157.74	$109.31	1.45%	$56.09	$78.94	$3,947.09
Dual	UnitedHealthcare	Central	$3,418.09	$157.54	$106.28	1.45%	$54.17	$76.25	$3,812.33
Dual	Banner - University Family Care	Central	$4,523.99	$119.90	$232.86	1.45%	$71.75	$100.99	$5,049.50
Dual	Mercy Care	Central	$4,600.09	$168.95	$126.78	1.45%	$72.03	$101.38	$5,069.23
Dual	Banner - University Family Care	South	$4,436.26	$110.44	$228.36	1.45%	$70.26	$98.88	$4,944.20
Dual	Mercy Care	South	$4,410.99	$167.87	$120.80	1.45%	$69.15	$97.32	$4,866.12
Non-Dual	UnitedHealthcare	North	$6,955.88	$326.19	$230.26	1.45%	$110.53	$155.57	$7,778.43
Non-Dual	UnitedHealthcare	Central	$7,642.37	$376.18	$254.14	1.45%	$121.72	$171.31	$8,565.72
Non-Dual	Banner - University Family Care	Central	$9,176.17	$487.06	$489.97	1.45%	$149.39	$210.26	$10,512.84
Non-Dual	Mercy Care	Central	$9,540.82	$169.99	$274.81	1.45%	$146.92	$206.79	$10,339.34
Non-Dual	Banner - University Family Care	South	$8,200.26	$393.93	$427.50	1.45%	$132.74	$186.83	$9,341.25
Non-Dual	Mercy Care	South	$8,051.35	$173.50	$221.25	1.45%	$124.27	$174.91	$8,745.28

Appendix 8a: State Directed Payments – CMS Prescribed Table

Appendix 8a: State Directed Payments – CMS Prescribed Tables

Table 1

Control name of the state directed payment	Type of payment - Section I.4.D.ii.(a)(i)(A)	Brief description - Section I.4.D.ii.(a)(i)(B)	Is the payment included as a rate adjustment or separate payment term? Sections I.4.D.ii.(a)(ii) and I.4.D.ii.(a)(iii)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	Minimum Fee Schedule	Contractors are required to adopt Prospective Payment System (PPS) rates as defined in the Medicaid State plan as a minimum fee schedule for FQHC/RHC providers.	Rate Adjustment
AZ_Fee_IPH.OPH.PC.SP.NF.HSBS.BHI.BHO.D_Renewal_20231001-20240930 (DAP)	Uniform Percentage Increase	Uniform percentage increase (which varies by provider class and qualifications met) to otherwise contracted rates. All providers were notified via a proposed and a final Public Notice of the criteria required to qualify for the DAP.	Rate Adjustment
AZ_Fee_AMC_Renewal_20231001-20240930 (APSI)	Uniform Percentage Increase	75% increase to otherwise contracted rates for professional services provided by eligible practitioners, applicable only to services covered under the AHCCCS APSI policy.	Separate Payment Term
AZ_Fee_IPH.OPH1 _Renewal_20231001-20240930 (PSI)	Uniform Percentage Increase	Uniform percentage increase for inpatient and outpatient services provided by the state's freestanding children's hospitals with more than 100 beds. The uniform percentage increase is based on a fixed total payment amount, and is expected to fluctuate based on utilization in the contract year.	Separate Payment Term
AZ_Fee_IPH.OPH2_Renewal_20231001-20240930 (HEALTHII)	Uniform Percentage Increase	Uniform percentage increase for acute inpatient and ambulatory outpatient contracted Medicaid Managed Care services. The uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class' aggregate targeted pay to cost ratio for Medicaid Managed Care services.	Separate Payment Term
AZ_Fee_NF_Renewal_20231001-20240930 (NF Supplemental Payments)	Uniform Dollar Amount	Uniform dollar increase across all Contractor's reported nursing facility Medicaid bed days to network providers that provide nursing facility services. The uniform dollar increase is based on available funds in the nursing facility assessment fund, plus FMAP, and is expected to fluctuate based on utilization and available funds for each quarter.	Separate Payment Term

Appendix 8a: State Directed Payments – CMS Prescribed Tables

Table 2

Control name of the state directed payment	Rate cells affected - Section I.4.D.ii.(a)(ii)(A)	Impact - Section I.4.D.(ii).(a)(ii)(B)	Description of the adjustment - Section I.4.D.(ii).(a)(ii)(C)	Confirmation the rates are consistent with the preprint - Section I.4.D.(ii).(a)(ii)(D)	For maximum fee schedules, requested information - Section I.4.D.(ii).(a)(ii)(E)
Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)	All EPD rate cells are affected.	See Appendix 8b for total impact by rate cell.	The impact of the minimum fee schedule requirement for FQHC/RHC providers is addressed as part of the fee schedule updates. The AHCCCS DBF Rates & Reimbursement Team developed the impacts of bringing the base FQHC/RHC encounter data up to the projected CYE 24 FQHC/RHC PPS rates, by applying the change in PPS rates as a unit cost change to the CYE 22 base data. The AHCCCS DBF Actuarial Team then reviewed the FQHC/RHC results and applied aggregated percentage impacts by program, GSA, risk group, and rate setting category of service as part of the overall fee schedule update.	Not applicable.	Not applicable.
AZ_Fee_IPH.OPH.PC.SP.NF.HSBS.BHI.BHO.D_Renewal_20231001-20240930 (DAP)	All EPD rate cells are affected.	See Appendix 6 for medical impact by rate cell. See Appendix 8b for total impact by rate cell.	The AHCCCS DBF Rates & Reimbursement Team provided the AHCCCS DBF Actuarial Team with data for the impact of DAP. The data used to develop the DAP impacts was the CYE 22 encounter data across all programs for the providers who qualify for DAP. The AHCCCS DBF Rates & Reimbursement Team applied the percentage increase earned under DAP to the AHCCCS provider payments resulting from the fee schedule changes, for all services subject to DAP, to determine what the impacts would be for the CYE 24 time period. The AHCCCS DBF Actuarial Team then reviewed the results and applied the percentage impacts by program and rate cell to the applicable categories of service to come to the final dollar impact for CYE 24 (the data provided by the AHCCCS DBF Rates & Reimbursement Team was at a detailed rate code and category of service level which the AHCCCS DBF Actuarial Team then aggregated to the specific rate cells for each program).	AHCCCS has submitted the DAP §438.6(c) preprint to CMS but has not yet received approval. The DAP payment arrangement accounted for in the capitation rates, and described here, is included in the capitation rates in a manner consistent with the preprint under CMS review.	Not applicable.

Appendix 8a: State Directed Payments – CMS Prescribed Tables

Table 3

Control name of the state directed payment	Aggregate amount included in the certification - Section I.4.D.ii.(a)(iii)(A)	Statement that the actuary is certifying the separate payment term - Section I.4.D.ii.(a)(iii)(B)	The magnitude on a PMPM basis - Section I.4.D.ii.(a)(iii)(C)	Confirmation the rate development is consistent with the preprint - Section I.4.D.ii.(a)(iii)(D)	Confirmation that the state and actuary will submit required documentation at the end of the rating period (as applicable) - Section I.4.D.ii.(a)(iii)(E)
AZ_Fee_AMC_Renewal_20231001-20240930 (APSI)	$4,798,907	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Access to Professional Services Initiative (APSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The APSI payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final APSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the APSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH1 _Renewal_20231001-20240930 (PSI)	$2,454,710	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Pediatric Service Initiative (PSI) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The PSI payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final PSI payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the PSI payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_IPH.OPH2_Renewal_20231001-20240930 (HEALTHII)	$62,332,274	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The HEALTHII payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final HEALTHII payment is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the HEALTHII payments into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.
AZ_Fee_NF_Renewal_20231001-20240930 (NF Supplemental Payments)	$95,851,058	The actuary certifies the aggregate directed payment estimates as actuarially sound according to 42 CFR § 438.4.	See Appendix 8b.	AHCCCS has submitted the Nursing Facility Supplemental Payments (NF-SP) 42 CFR § 438.6(c) preprint to CMS, but has not yet received approval. The NF-SP payment arrangement is accounted for in a manner consistent with the preprint under CMS review.	After the rating period is complete and the final NF-SP is made, AHCCCS will submit documentation to CMS which incorporates the total amount of the NF-SP into the rate certification's rate cells, consistent with the distribution methodology included in the approved state directed payment preprint, and as if the payment information had been fully known when the rates were initially developed.

Appendix 8b: State Directed Payments – Estimated PMPMs

Appendix 8b: State Directed Payments - Estimated PMPMs

			I.3.B.ii.	I.4.D.	I.4.D.	I.4.D.	I.4.D.	I.4.D.
Rate Cell	Contractor	GSA	FQHC/RHC	DAP	APSI	PSI	NF-SP	HEALTHII
Dual	UnitedHealthcare	North	$0.06	$58.86	$0.28	$0.00	$378.50	$31.41
Dual	UnitedHealthcare	Central	$0.01	$47.91	$0.75	$0.01	$214.67	$31.92
Dual	Banner - University F	Central	$0.02	$74.21	$1.30	$0.00	$308.56	$48.78
Dual	Mercy Care	Central	$0.01	$81.67	$1.52	$0.01	$262.33	$70.79
Dual	Banner - University F	South	$0.04	$87.37	$1.16	$0.00	$345.17	$36.74
Dual	Mercy Care	South	$0.14	$72.83	$1.54	$0.00	$335.16	$55.49
Non-Dual	UnitedHealthcare	North	$3.19	$107.44	$24.10	$11.69	$367.69	$902.50
Non-Dual	UnitedHealthcare	Central	$5.87	$113.51	$68.88	$73.94	$324.15	$793.22
Non-Dual	Banner - University F	Central	$4.47	$147.09	$82.15	$43.00	$417.78	$720.81
Non-Dual	Mercy Care	Central	$4.88	$156.48	$79.41	$50.99	$350.96	$890.89
Non-Dual	Banner - University F	South	$10.04	$152.78	$117.44	$7.71	$346.72	$1,083.32
Non-Dual	Mercy Care	South	$12.75	$136.48	$81.53	$4.85	$392.32	$677.60